



Indian Health Service FY 2002 Performance Plan and FY 2000 Performance Report

April 6, 2001

Congressional Justification Submission

Part I - AGENCY CONTEXT FOR PERFORMANCE MEASUREMENT

Tomorrow

We have wept the blood of countless ages as each of us raised high the lance of hate.

Now let us dry our tears and learn the dance and chant of the life cycle.

*Tomorrow dances behind the sun in sacred promise of things to come for children not yet born,
for ours is the potential of truly lasting beauty, born of hope and shaped by deed.*

Peter Blue Cloud

Overview of the Context of GPRA in the IHS

The Indian Health Service (IHS) has embraced the Government Performance and Results Act (GPRA) and its requirements as an extension of the public health approach that we have used for almost a half of a century. In this document the initial FY 2002 and revised final FY 2001 Performance Plans have been merged with the FY 2000 Performance Report consistent with the required format developed within the Department of Health and Human Services (HHS). This plan is submitted as our best effort at meeting the demanding challenge of the proposed *Healthy People 2010* goal of achieving equivalent and improved health status for all Americans over the next decade. It presents a strategic set of performance indicators to address the significant health problems the American Indian and Alaska Native (AI/AN) population experience.

Indeed the disparity in health status that the IHS must address is formidable, particularly in terms of death rates. Comparing the 1996-1998 Indian (IHS service area) age-adjusted death rates with the U.S. all races population in 1997 reveals greater death rates in the AI/AN population for:

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| 1) alcoholism - 638% greater, | 6) pneumonia and influenza - 67% greater, |
| 2) tuberculosis - 400% greater, | 7) homicide - 81 % greater, |
| 3) diabetes mellitus - 291% greater, | 8) gastrointestinal disease- 38% greater, |
| 4) unintentional injuries - 163% greater, | 9) infant mortality - 24% greater, and |
| 5) suicide - 91% greater, | 10) heart disease, 20% greater. |

It was not surprising that a recent Harvard School of Public Health/Centers for Disease Control and Prevention (CDC) study found that the lowest life expectancies in the country (including inner city ghettos) for both men and women exists in Indian communities. These rates are similar to ones seen in sub-Saharan Africa and are the lowest of any nation in this hemisphere except Haiti. It is also not surprising that these Indian people have also been identified as living in the poorest counties in the country. Even more alarming, the most recent data (provided in Section 1.2 of this plan) documents that the mortality disparities for AI/AN people are actually worsening.

Despite these formidable challenges, the IHS in partnership with its stakeholders, view the GPRA as part of the process for assuring the capacity to serve AI/AN people. We are optimistic about the future and encouraged and appreciative of the support of the Department, OMB, and Congress in the development of this and last year's budgets and of the improved level and quality of consultation that has occurred with tribes. In particular, the regional meetings/ listening sessions convened by the Department's leadership provided a valuable dialogue process that was

informative and empowering to the AI/AN people and should contribute to enhanced collaborative activities within and outside the Department.

The performance indicators in this plan are predominately directed at improving access to health services for AI/AN people. However, it is important to acknowledge that due to the nature of many of the diseases and conditions afflicting AI/AN people, they are not likely to respond immediately to increased access to services. Like an ocean liner or large freight train which continues to move forward for a considerable time even after the engines are reversed, so will some chronic and/or life-style related conditions continue to afflict the AI/AN population. For these conditions, improved health outcomes are likely to take several or many years before they are realized. Thus, initially it will be a significant challenge to stop the escalation of disease mortality and morbidity evident from the most recent data presented in Section 1.2 of this document.

This plan and its predecessors represents significant efforts over the past three years by the IHS and its diverse stakeholders in which a "bottom-up" approach to budget formulation and GPRA performance planning has been used. This approach was adopted to support the Indian self-determination process and honor the "government to government" relationship that exists with tribes. Beginning with the development of the FY 1999 budget and Performance Plan, regional meetings were held to outline the GPRA and budget formulation process for all IHS Area Formulation Teams.

These Area teams then provided representatives of their local programs the opportunity for input and review of the Area recommendations, which were then compiled. For the past three years Area Formulation Team representatives then came together along with tribal leaders and representatives from several Indian organizations to merge and reconcile the Area recommendations into a single IHS set of budget priorities.

Using these identified budget priorities, a multidisciplinary team of stakeholders that included health program, budget, and information technology experts, epidemiologists, and IHS and tribal managers developed this plan. In addition to the identified budget priorities this plan reflects the context of the Department of Health and Human Services (HHS) Strategic Plan and the *Healthy People 2010* goals and objectives.

This performance plan and the requested budget that underpins it, represent a cost-effective public health approach to best address the health disparities that prevail for AI/AN people. By most objective measures of efficiency and effectiveness in addressing health problems, we have been and are frugal and have a proud history of accomplishments that document the achievement of significant results long before it was required by law. Over the next decade, in partnership with our stakeholders, we can accomplish even more.

1.1 Agency Mission and Long-Term Goals

The Indian Health Service (IHS) has the responsibility for the delivery of health services to Federally-recognized American Indians and Alaska Natives (AI/AN) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. In 1995 a group of stakeholders charged by the IHS Director to reorganize the IHS, revised the mission and goal and added a foundation as follows:

MISSION:

The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

GOAL:

To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

FOUNDATION:

To uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

These three responsibilities have been integrated into the evolving IHS component of the Department of Health and Human Services (HHS) Strategic Plan for the GPRA to yield four broad IHS Strategic Objectives to guide the Agency into the next millennium. The first is essentially a restatement of the HHS Strategic Plan Objective 3.6 *Improve the health status of American Indian and Alaska Natives*, while the remaining three strategic objectives represent the means to achieve the first:

Strategic Objective 1: Improve Health Status

To reduce mortality and morbidity rates and enhance the quality of life for the eligible American Indian and Alaska Native population.

Strategic Objective 2: Provide Health Services

To assure access to high quality comprehensive public health services (i.e., clinical, preventive, community-based, educational, etc.) provided by qualified and culturally sensitive health professionals with adequate support infrastructure (i.e., facilities, support staff, equipment, supplies, training, etc.)

Strategic Objective 3: Assure Partnerships and Consultation with I/T/Us

To assure that I/T/Us, and IHS Area Offices and Headquarters achieve a mutually acceptable partnership in addressing health problems:

- *providing adequate opportunities for I/T/Us and American Indian and Alaska Native organizations to participate in critical functions such as policy development and budget formulation, and*
- *assuring that I/T/Us have adequate information to make informed decisions regarding options for receiving health services.*

Strategic Objective 4: Perform Core Functions and Advocacy

Consistent with the IHS Mission, Goal and Foundation, to effectively and efficiently:

- *execute the core public health and inherent Federal functions, and*
- *advocate for the health care needs of the American Indian and Alaska Native people.*

These Strategic Objectives are essential for the realization of our Mission, Goal, and Foundation over the next five to 10 years by setting the programmatic, policy, and management course for the IHS. They are also consistent with the most recognized approach to evaluating health care organizations in that they address the *structure, process, and outcomes* of health care delivery and provide the conceptual and philosophical framework for the performance indicators outlined in this annual performance plan.

During FY 2001, the IHS and its stakeholders will develop a process to identify specific long-term quantifiable health status and health care measures that will serve as benchmarks for focusing improvement efforts for the future. In essence, this effort will establish quantified targets for Strategic Objectives 1 and 2 and will require broad tribal consultation to secure acceptance and support. Preliminary work with stakeholders has identified several potential health measures to consider as long-term improvement targets for the AI/AN population that include:

- years of potential life lost
- accident/injury death rate
- diabetes prevalence and death rates
- infant death rate
- immunization rates for children and adults
- Quality of Life Index
- cancer survival rate
- obesity prevalence rate
- suicide rate
- rate of children free of dental decay and adults with 20 or more functional teeth
- prevalence of substance abuse (i.e., alcohol, drugs, and tobacco)
- percent of homes with adequate water and sewage facilities

Data for many of these measures are already available or soon will be. Developing strategies for securing data for selected measures not currently available will be a major part of this effort.

Clearly making measurable improvements in these health measures is mission critical because they represent many of the areas of greatest disparities between the AI/AN people and the U.S. general population. Eliminating only these disparities within even 20 years would represent a public health accomplishment of unparalleled magnitude in recent history.

1.2 Organization, Programs, Operations, Strategies and Resources

Humankind has not woven the web of life. We are but one thread within it. Whatever we do to the web, we do to ourselves. All things are bound together. All things connect

Chief Seattle

The IHS is the Operating Division (OPDIV) within HHS charged with administering the principal health program for the eligible AI/AN population. The IHS provides comprehensive health services through its I/T/U system of facilities and programs. Many of the people served by the IHS live in some of the most remote and poverty stricken areas of the country, and these health services represent their only source of health care. In terms of magnitude, the I/T/Us provide health services to over 1.3 million people through 151 service units composed of 550 health care delivery facilities, including 49 hospitals, 214 health centers, 7 school health centers, and 280 health stations, satellite clinics, and Alaska village clinics.

Within this system, Indian tribes deliver IHS-funded services to their own communities with about 44 percent of the IHS direct services budget in 12 hospitals, 155 health centers, 3 school health centers, and 239 health stations, satellite clinics, and Alaska village clinics. Tribes who have elected to retain the Federal administration of their health services at the present time receive services with about 56 percent of the IHS direct services budget in 37 hospitals, 59 health centers, 4 school health centers, and 44 health stations and satellite clinics. The range of services includes inpatient and ambulatory care, extensive preventive care, and a diversity of health promotion and disease prevention activities.

In addition, various health care and referral services are provided to Indian people away from the reservation settings through 34 urban Indian health programs. It is estimated that almost 60 percent of all AI/ANs now reside in or near urban centers and available evidence suggests they have considerable health care needs. The Contract Health Services program is an integral part of the IHS system for purchasing services from non-IHS providers to support, or in some cases in lieu of, direct care services. Contract Health Services represents about 18 percent of the IHS Budget and is distributed to IHS and Tribal programs at the same relative percentage as direct services funding (i.e., IHS = 59%, Tribal = 41%). In FY 1999, the IHS Fiscal Intermediary processed approximately 360,000 payment claims.

Since its inception in 1955, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. This contention is supported by dramatic improvements in mortality rates between 1972-74 and 1994-96, including:

- maternal mortality reduced 78% (27.7 to 6.1 per 100,000)
- tuberculosis mortality reduced 82% (10.5 to 1.9 per 100,000)
- gastrointestinal disease mortality reduced 76% (6.2 to 1.5 per 100,000)
- infant mortality reduced 66% (22.2 to 7.6 per 100,000)
- accident mortality reduced 57% (188.0 to 80.6 per 100,000)
- pneumonia and influenza mortality reduced 50% (40.8 to 20.2 per 100,000)

When compared with the U.S. general population, the IHS achieved these improved outcomes in the face several complicating factors including:

- lower per capita expenditures for health care
- limited availability of providers (e.g., half the physicians and nurses per capita)
- higher costs for providing health care in isolated rural settings (loss of economies of scale)
- lack of facilities in numerous locations and many outdated existing facilities (i.e., average age of IHS facilities is 32 years in comparison to 9 years for the private sector)
- lower utilization of health care services (e.g., 25% annual utilization of dental service for AI/ANs compared to about 60% for US population overall)
- significantly higher health care needs because of poor health status (significantly higher rates of diabetes, alcoholism, injuries, oral diseases, and overall death rate)
- high unemployment, poverty, substandard housing, and other recognized contributing factors to reduced health status

While overall outpatient visits have steadily increased with the AI/AN population growth of over two percent annually, decreases have occurred in access to non-urgent primary services that include:

- 37% decline in the number of well child services between FY 1992-97
- 35% decline in the number of physical exams between FY 1994-97
- 26% reduction in the proportion of people receiving dental services between FY 1992-99
- 68% reduction in water systems fluoridated between FY 1991-99
- 128% increase in denials of claims from health care contractors between FY 1994-99

In this context, the increasing demand for urgent care that has reduced the capacity of the IHS to provide the primary services that are critical to long-term health maintenance and improvement. Of greatest concern are the most recent mortality data (FY 1998) available from the National Center for Health Statistics adjusted for miscoding of AI/ANs. These data document an upward trend in deaths of AI/AN people for the period of 1996-98 compared to the period 1994-96 from cancer, diabetes, suicide, motor vehicle accidents, and heart disease. The net result of these categorical increases is an overall increase in death rate for AI/AN people from 699 per 100,000 population for the period 1994-96 to 715 per 100,000 population for the period 1996-98. With the U.S. general population mortality rate declining during these comparable time periods from 504 per 100,000 population to 479 per 100,000 population, it is clear the health disparity gap relative to AI/AN mortality is worsening. Chart I on the following page outlines these disturbing AI/AN mortality trends.

Chart I

MORTALITY RATE DISPARITIES CONTINUE

American Indians and Alaska Natives in the IHS Service Area 1994-96 to 1996-98 and U.S. All Races 1995 and 1997 (Age-adjusted mortality rates per 100,000 population)

	AI/AN Rate 1996-98	U.S. All Races Rate 1997	Ratio: AI/AN to U.S. All Races	AI/AN Rate 1994-96	U.S. All Races Rates 1995	Ratio: AI/AN to U.S. All Races
ALL CAUSES	715.2	479.1	1.5	699.3	503.9	1.4
Alcoholism	46.5	6.3	7.4	48.7	6.7	7.3
Tuberculosis	1.5	0.3	5.0	1.9	0.3	6.3
Diabetes	52.8	13.5	3.9	46.4	13.3	3.5
Motor Vehicle Crashes	54.8	15.9	3.4	54.0	16.3	3.3
Suicide	20.2	10.6	1.9	19.3	11.2	1.7
Homicide	14.5	8.0	1.8	15.3	9.4	1.6
Cervical Cancer	4.2	2.5	1.7	3.3	2.5	1.3
Infant Deaths ^{1/}	8.9	7.2	1.2	9.3	7.6	1.2
Diseases of the Heart	157.1	130.5	1.2	156.0	138.3	1.1
Cerebrovascular Diseases	29.5	25.9	1.1	30.5	26.7	1.1
Malignant Neoplasms (All)	124.0	125.6	1.0	116.6	129.9	0.9
HIV Infection	3.3	5.8	0.6	6.2	15.6	0.4

^{1/} Infant deaths per 1,000 live births.

NOTE: American Indian and Alaska Native rates were adjusted to compensate for race misreporting on State death certificates.

Given these trends and challenges, the IHS and its diverse stakeholders have been reorganizing the IHS and are continually developing alternative methods to assure more efficient health programs and administrative support to Indian communities. The redesign efforts emphasize patient care; strengthening government to government relations; streamlining administration and management; quality support services to field-based health care activities; diversification of operations; staffing new facilities; and fair treatment of employees. This performance plan supports and provides quantifiable measures for each of these priorities.

The budget supporting this performance plan proposes provides linkage to a multidisciplinary approach that crosscuts programs key to addressing complex health problems associated with chronic diseases and harmful behavioral health practices. This approach includes enhancing the integration of our diverse expertise from medical, behavioral health, and community health staff in order to address the top health problems identified by the I/T/Us. Emphasizing prevention strategies throughout the clinical service activities strengthens the community-based public health model. Furthermore, it is essential to maintain community health programs and supporting partnerships with community resources such as public safety programs, schools, and other community based organizations.

The first priority in the budget request is to maintain and in some cases increase access to basic health services for AI/AN people. In this context, the request addresses the multiple health issues affecting the AI/AN population and to assure the health of the AI/AN population does not continue its downward trend. The proposal targets the health problems identified as highest priorities by the I/T/Us and responsible for much of the disparity in health status for the AI/AN population. These include alcoholism and substance abuse, diabetes, cancer, mental health, elder health, heart disease, injuries, dental health, maternal and child health, domestic violence, infectious diseases, and sanitation.

The support for public health infrastructure is also fundamental to these activities. These investments will maintain surveillance, prevention and treatment services and are based on "best practices" defined in the public health literature. This approach is consistent with the trend of Federal entities adopting such industry standards. Many of the IHS performance indicators for "treatment" and "prevention" represent our commitment to this process.

An essential component of supporting access to services is to assure that there are adequate facilities and equipment for the provision of health services. The IHS must assure an efficient, safe, and pleasant environment for the provision of services by ongoing maintenance, repair, renovation, and replacement of health care facilities. The funding request for these functions is underpinned by performance measures in the section addressing Capital Programming/Infrastructure.

Also critical is the provision of contract support costs to the tribal health delivery system. These requested funds will provide for tribal communities to assure that there are utilities, training, clerical staff, administrative and financial services needed to operate health programs. This investment is consistent with the Administration's commitment to supporting tribal participation in the management of the programs and the principles of the Indian Self-Determination Act.

Another target of the FY 2002 funding request is water and sewer systems for new and existing homes at the community level to support further progress in preventing infectious diseases and improving the quality of life and is thus specifically addressed in this plan. This performance

plan backs this request with a specific performance measure as part of the Capital Programming/Infrastructure section of this document.

In summary this performance plan and budget request represents a commitment to utilized available resources to the maximum benefit in achieving our mission of improved health status for the AI/AN people.

1.3 Partnerships and Coordination

Given the magnitude of AI/AN health disparities and the resource demands they create, it is critical that the IHS identify and collaborate with all available outside organizations with the capacity, capability, and interest to assist in addressing these diverse health problems. Our resolve to develop this crosscutting network is evident by the number and diversity of collaborative activities that are currently in place and described in section.

The Indian Health Service has continued to develop and expand its crosscutting collaborations and partnership with other agencies and organizations to achieve common goals and objectives addressing health disparities of American Indians and Alaska Natives (AI/AN). These partnership and collaborations are building capacity across institutions, enhancing program outreach through shared resources, opening dialogue with new partners, developing or disseminating new health care and/or surveillance technologies, securing a variety of training and technical assistance support for I/T/U providers, networking to maximize knowledge and resources, disseminating information through activities of mutual concern, and developing tribally specific community-based, community driven research.

The following examples of recent and developing collaborative activities met one or more of the following criteria:

- clearly presents the true influence that the Federal agency and its programs wield
- shows program coordination as key elements of interest with GPRA implementation to achieve performance goals
- clarifies roles of the agency, related Federal agencies, and performance partners
- demonstrates agency strategy to coordinate efforts of crosscutting programs-activities
- documents uniqueness of the agency and its distinguishable contributions
- presents agency plans for eliminating duplication and overlap

PROGRAM COORDINATION BY PARTNER WITHIN DHHS:

Administration for Children and Families/Head Start Bureau

- The IHS and the Administration for Children and Families (ACF) have a longstanding collaboration (five years) with the Head Start Bureau. The technical assistance is for IHS to provide Health and Safety training and technical assistance to the 177 Head Start grantees, which are part of the American Indian Program Branch of the ACF, in the area of Health and Safety, Nutrition, Dental, Behavioral Health and General Medical Services. The collaboration also results in a full-time health and safety specialist position and a computerized data system for the IHS Head Start program.

- The IHS and the ACF are collaborating with the IHS Diabetes program, Nutrition program and the clinical providers to monitor and develop programs to address the 0-5 age group of AI/AN in prevention. This is an intervention program to address rising trends in obesity in this age group.

Agency for Healthcare Research and Quality

- The IHS and AHRQ co-sponsored a conference entitled "Crafting the Future of American Indian and Alaska Native Health into the Next Millennium." The purpose was to promote health care partnerships, including research partnerships, between academic medical centers and AI/AN organizations and tribes. IHS and AHRQ are maintaining collaborative efforts; strengthening health services research; increasing opportunities for the Native American population into research; and strengthening the research infrastructure of AI/AN organizations.
- The AHRQ Office of Research Review, Education and Policy (ORREP) is collaborating on potential research training for AI/AN people. The ORREP also participated in the Annual IHS Research Conference. Discussions regarding additional research possibilities have been held with other AHRQ staff.
- The AHRQ Center for Practice and Technology Assessment and the IHS have had discussions regarding possible collaboration and services through their evidence-based practice centers, including technology assessment and other related research activities.
- A collaboration with AHRQ is being pursued to support an Indian Primary-Care Based Research Network
- A collaboration with AHRQ is being discussed for development in 2002 to field an update of the Survey of American Indian and Alaska Natives (SAIAN) as part of the Medical Expenditures Planning Survey (MEPS).
- The collaboration continues on the development of the Healthcare Utilization Project to incorporate IHS data into a large nationwide inpatient database that AHRQ manages with the States.

Centers for Disease Control and Prevention Umbrella Agreement

The IHS and CDC have extensively collaborated in addressing a diversity of health issues over the past decade. As a result, the IHS and CDC now annually develop an umbrella agreement and work plan that currently addresses:

- **CDC/Agency for Toxic Substances and Disease Registry Tribal Liaison:** The purpose of this position is to strengthen inter-government response to tribal public health needs through consultation, networking, strategic planning, and improved coordination among federal and state governments, tribal communities, urban Indian health programs, and academic institutions. This helps to ensure that Indian health interests are represented in program decisions and policies.

- **Epidemiology/Preventive Medicine Training:** The IHS National Epidemiology Program hosts CDC Epidemic Intelligence Service (EIS) Officers for their two-year field epidemiology training experience, and Preventive Medicine Residents (PMRs) for a one-year field training. IHS can provide similar assignments for Prevention Specialists (Public Health Prevention Service). It provides the trainees practical experience while providing a service to the IHS. The IHS Epidemiology and the CDC/EPO are currently collaborating on a project to make basic epidemiology training available to tribal health departments; Navajo Nation is the pilot site.
- **CDC/National Center for Chronic Disease Prevention and Health Promotion-Chronic Disease Annual Workplan:** This intra-agency agreement/workplan was developed in 1990 consisting of two distinct segments, the R-90 (services provided by IHS to CDC) and the M-90 (services provided by CDC to IHS). Both segments consist of an array of components, the specifics of which are negotiated on an annual basis in the form of a workplan. In many cases IHS provides the FTE and CDC provides salaries for some of the staff supporting these activities. Highlights of this plan follows:
 - **Division of Cancer Prevention and Control (DCPC):** Provides for a field assignment for a CDC Public Health Advisor (PHA) to provide technical assistance/guidance for capacity building with state health departments, IHS tribes and tribal organizations. DCPC also provides funds for colposcopy training and other IHS cancer control activities. IHS provides an additional three FTE's to CDC, located in Atlanta, for direct technical assistance and consultation to tribes and tribal organizations through the National Breast and Cervical Cancer Early Detection Program, which currently funds 14 tribal screening programs.
 - **Division of Adult and Community Health (DACH):** IHS provides DACH with four FTE's located in Atlanta to support research, technical assistance, training, and planning. DACH will be the lead in overall planning, coordinating, and monitoring of chronic disease-related activities. The principal activities include but are not limited to:
 - **Memorandum of Understanding - IHS CDC/University of New Mexico:** The IHS provides an FTE for a field assignee with a Doctorate in epidemiology or related field to serve as a Senior Research Scientist for University of New Mexico Prevention Research Center for activities related to AI/AN communities.
 - **Health Promotion Activities for Older Adults:** This component provides technical assistance in the design, implementation and analysis of surveys for health promotion activities for older adults. Information from these surveys will be used to direct program development and evaluation of the health needs of AI/AN aged 55 and older.
 - **Behavioral Surveillance Branch (BSB):** Using the CDC Behavioral Risk Factor Surveillance Survey (BRFSS) this collaboration responds to requests from tribal epidemiology centers (Alaska Native EPI Center, Inter-Tribal Council of Arizona; Northwest Tribal Research Center, and Great Lakes Inter-Tribal Council) to assist in creating and/or analyzing BRFSS data files.

- **Cardiovascular Health:** The DACH provides technical assistance in the design, implementation, and evaluation of cardiovascular risk factor prevention and intervention programs. Provides dissemination of lessons learned from the Inter-Tribal Health Project (ITHP) to tribal communities in the Bemidji service area of IHS and throughout the United States.
- **Division of Oral Health:** This agreement includes a component to develop, implement and promote water fluoridation in AI/AN communities for dental disease prevention. A field assignee will be placed in Albuquerque with the IHS Environmental Management Branch.
- **Division of Diabetes Translation (DDT):** The IHS provides one FTE located in Atlanta, to support CDC/DDT in providing technical consultation and assistance on public health surveillance of diabetes to define the burden of diabetes and diabetes-related complications among the Native population. The DDT calculates age-specific and age-adjusted prevalence by area; hospitalizations and amputations. The CDC/DDT also provides a field assignee to IHS diabetes Program in Albuquerque to provide consultation and technical assistance in diabetes epidemiology to IHS.
- **Gallup Diabetes Research Center:** The IHS provides five FTEs and funding to NCCDPHP to support the National Diabetes prevention research Center in Gallup, New Mexico. The IHS and the NCCDPHP will jointly provide national leadership to plan, develop, implement and evaluate the National Diabetes Prevention research Center under the broad guidance of the Departments of Labor, health and Human Services, Education, and Related Agencies congressional Appropriations act, H.R. 2264, 1998 Conference Report, page S-12088.
- **Office on Smoking and Health (OSH):** The IHS provides CDC/OSH with one FTE for a field assignee located in Albuquerque, New Mexico, to develop, establish, and maintain a community based program for the prevention and control of tobacco use, and related health problems among AI/AN populations.
- **Division of Reproductive Health (DRH):** The IHS provides three FTEs to DRH to support a multifaceted approach to addressing reproductive-related health problems in AI/AN, including Sudden Infant Death Syndrome, and to assist tribes in community health surveys. One method is collection and analysis of reproductive health and Behavioral Risk Factor Surveillance (BRFS) information. After data collection, DRH assists tribes and organizations in the analysis, interpretation and dissemination of survey data. The Pregnancy Risk Assessment Monitoring System (PRAMS) conducts State-specific, population-based surveillance of women's behaviors before, during pregnancy and during the child's early infancy. Two FTE's are located in Atlanta and one FTE provides for a field assignee located in Albuquerque, New Mexico.
- **National Center for HIV, STD and TB Prevention (NCHSTP)**
 - **Division of Sexually Transmitted Disease Prevention:** The IHS provides an FTE for the field assignment of a Public Health Advisor (PHA) to assist in the planning,

development and implementation of sexually transmitted disease control programs among AI/AN. The PHA is located in Albuquerque, New Mexico.

- Communicable/Sexually transmitted Disease Prevention and Control: The IHS provides one-half time services of an Epidemiologist to share administratively the activities under this agreement. The agreement provides for the prevention and control of communicable and other sexually transmitted diseases among AI/AN. High rates of Chlamydia trachomatis may be found throughout AI/AN populations. Activities will include: developing and implementing surveillance systems for monitoring trends; initiating and managing national evaluation, screening and intervention programs and identifying high risk populations for other sexually transmitted disease including HIV.
- **Division of HIV/AIDS Prevention:**
 - Under another collaborative agreement that has been completed an epidemiologist will be designated to assist in the coordination of national surveillance, prevention, and control activities for HIV/AIDS and related opportunistic infections, STDs, and hepatitis B and C among AI/AN people.
 - Further collaboration with CDC/Division of Adolescent and School Health (DASH) is being conducted to provide HIV prevention program activities for the implementation and evaluation of HIV prevention education for AI/AN children and youth in schools on reservations, rural areas, and urban metropolitan areas. Training will be provided to teach in States that have a significant number of Indian students in the use of a curriculum, "Circle of Life HIV/AIDS Curriculum", developed by IHS. The curriculum is for grades K through 6th.
- **National Center for Infectious Diseases (NCID)**
 - Division of Viral and Rickettsial Diseases, Hepatitis Branch: The IHS provides an FTE for a field assignment to be located in Albuquerque, New Mexico, of an epidemiologist to assist in the planning development, and implementation of hepatitis prevention and control programs among AI/ANs. The purpose of this agreement is to provide for collaborative activities related to prevention and control of hepatitis A and C in AI/AN communities. The ultimate goal is to reduce the incidence of hepatitis as a health problem in AI/AN populations.
 - Special Pathogens Branch: The IHS and CDC have an ongoing intra-agency agreement that targets the hantavirus disease. The purpose of this agreement is to assist in the planning, development and implementation of hantavirus prevention and control programs among AI/ANs. Support provided includes assistance in determining trends in hantavirus morbidity and mortality; identifying and responding to outbreaks; and collaborating with tribal, state and local health departments and community-based organizations.
- **National Center for Injury Prevention and Control (NCIPC)**: The NCIPC has had an intra-agency agreement with IHS since 1985 to help reduce unintentional and intentional injuries among AI/ANs. The CDC has assisted IHS with pilot injury surveillance projects, publishing MMWR reports and Surveillance Summaries, teaching in the IHS Injury

Prevention training program to build tribal capacity, evaluating community-based injury prevention and control programs, participate in the IHS's national advisory board on injuries, and collaborate as a national partner to raise awareness of injuries as a leading public health problem among AI/ANs. The CDC and the IHS also collaborated with the American Academy of Pediatrics and several tribal groups to present the first ever briefing on injury issues to select Senate staff. The IHS provides an FTE for an Atlanta-based Injury Prevention Specialist who collaborates with IHS on these and other projects.

- **National Immunization Program (NIP)**

- Vaccine-Preventable Disease Control: The IHS provides an FTE for the field assignment of a Public Health Advisor to assist in the planning, development and implementation of vaccine-preventable disease control programs among AI/ANs. The PHA, located in Albuquerque, New Mexico, will assist in implementation of the Vaccines for Children (VFC) program among AI/AN children.

OTHER IHS/CDC COOPERATIVE AGREEMENTS : The IHS and CDC collaborate on various specific projects in partnership with tribes, tribal coalitions, Alaska Native corporations, and academic institutions who are recipients of CDC and/or IHS cooperative agreement funds. Such activities may or may not occur in direct relationship to the aforementioned formal Intra-agency Agreements.

Food and Drug Administration

- The IHS and the FDA collaborated on recommendations to reduce patient and occupational exposures; to promote principles of radiation protection, and to allow the FDA to monitor radiation protection for conformance with existing agency and Federal policies.
- The IHS has a collaborative agreement with the FDA Center for Devices and Radiological Health for mutual support in the evaluation and use of medical radiologic equipment. During the past year the FDA provided equipment and training to allow IHS institutional environmental health staff to conduct performances and quality assurance evaluations of 300 medical and 1,000 dental diagnostic x-ray units.

Health Care Financing Administration

The collaboration with HCFA covers an array of issues that critically impact operational issues related to the Indian health care system and the provision of services by the IHS to its stakeholders. Many of the issues were directed at increasing the understanding of federal and state government agencies about the government-to-government relationship with the 550 federally recognized tribes and the need for consultation with tribal governments on actions that affected them. Following are current and ongoing collaboration issues.

- The IHS and HCFA Joint Indian Health Steering Committee continues to be an effective tool creating a better understanding of the unique needs of the IHS and, Tribes (I/T) for appropriate, representative policies.
 - Legislation Subcommittee: The IHS will continue to work with HCFA on legislative directives, e.g., reauthorization of the Indian Health Care Improvement Act, using

Medicare rates for CHS payments, expanding payments to outpatient ambulatory clinics and for physician services.

- Operations Subcommittee: The IHS will continue to work with HCFA on program policy and operation issues such as reimbursement policies, outreach and education, and data sharing and other policy guidance.
 - Cost Reports Subcommittee: The IHS in collaboration with HCFA will address short and long range plans for development of hospital cost reports. This includes short and long range plans for a cost accounting system, and training of IHS finance and management staff
- The IHS and HCFA continue their collaboration with the National Medical Education program (NMEP) Task Force. The NMEP ensure that beneficiaries receive accurate, reliable information about their benefits, rights and health plan options; have the ability to access information needed to make informed choices; and perceive the NMEP (the Federal government and our private sector partners) as trusted and credible sources of information. The NMEP activities have included publishing Medicare & You Handbook, Internet activities, Toll-Free Medicare choices Helpline, National Alliance Network, Enhanced Beneficiary Counseling from State Health Insurance Assistance programs, the National Train-the-Trainer Program, and Regional Education About Choices in Health Campaigns.
 - The IHS and HCFA formed the Home Health Care workgroup to develop draft regulations to implement the Prospective Payment System. The workgroup will be reviewing amendments to the current regulations.
 - The IHS and HCFA work closely on the HHS Value-Based Purchasing Work Group that is part of the Quality Interagency Coordination Council. They have pursued the national goal to reduce the number of medical errors in health care environments and to build a safer health system nationally.
 - The establishment of an IHS Liaison to advise HCFA managers on policy information respective to health care programs administered by the I/T/U continues to be beneficial and effective.
 - The IHS and HCFA collaborated for the Prospective Payment System Minimum Data Sets that include current cost reports. These files are used to calculate hospitals' current Diagnostic Related Group prospective payment rates, etc. The intent of these data sets are to provide IHS with the necessary information to make payments in a timely manner.
 - The IHS and HCFA collaboration resulted in new Medicare and Medicaid reimbursement rates for the IHS and IHS-funded tribal facilities. This revenue source is used for medical staff, improved training, the purchase of additional medical equipment and improved facilities for IHS.
 - The IHS and HCFA collaborated on legislative issues that resulted in important HCFA policies and enhanced operational issues, i.e. Medicaid program waivers, the Children's Health Insurance Program (CHIP), new policy guidance and proposed regulations exempting AI/AN from any cost sharing provisions under CHIP for eligible children.

- The IHS and HCFA collaborated on Medicare enrollment data to provide more accurate information for assessing outreach to Medicare beneficiaries that are AI/AN to establish an accurate database for IHS. This information will be used also for analyzing AI/AN Medicare utilization patterns. Also, this database will be used by the IHS in claims processing to reduce the number of IHS Medicare claims rejected by HCFA fiscal intermediaries for errors.
- The IHS/HCFA collaborated together to discuss major issues affecting the policies and operations of each agency such as interfacing with state health care reform activities, federal waiver demonstrations, advising HCFA HQs and Regional Officers, State Medicaid Directors on how to consult with tribes in their States when drafting Medicaid waiver proposals.

Health Resources and Services Administration

- The IHS continues to collaborate with HRSA to provide support for PHS Primary Care Policy Fellowship program to bring 30 Federal and private sector primary care leaders to enhance their capabilities to advance the primary care agenda at the local, state, and national level. It also sponsors a mid-year Primary Care Networking Conference for collaborations.
- The IHS and HRSA have recently completed an agreement to provide HIV/AIDS education and training to health care providers that provide health care services to AI/AN people.
- The IHS and HRSA-Federal Occupational Health Program (FOHP) collaborated to share software enabling IHS to receive occupational health, environmental assessment and health information management support services from various resources and enables the IHS to meet its environmental management responsibilities.

National Institutes of Health

- The IHS and the National Institute of General Medical Sciences (NIGMS) are collaborating on bringing together in partnership academic research institutions, Indian tribes or Indian community based organizations. The purpose is to strengthen capacity for research on diseases of importance to American Indians and to develop a cadre of American Indian scientists and health professionals who will become active participants in competitive NIH funded research.
- The IHS and the NIH- National Institute for Dental and Craniofacial Research, in partnership with the State University of New York at Buffalo have a longstanding (five year) partnership to develop treatment regimens for individuals with diabetes who also suffer from periodontal disease. The first site for the study was Sacaton, Arizona, and the current site is Santa Fe, New Mexico. The results have been reported in the professional literature and the technology is being exported under a grant program.
- The IHS and NIH-National Institute of Diabetes and Digestive Kidney Diseases (NIDDK) collaborate on facilities and services to conduct clinical research studies primarily in the areas of diabetes and digestive diseases at the Phoenix Indian Medical Center (PIMC), Arizona. It also facilitates collaborative research interest in diabetic renal disease and epidemiologic surveys and studies.

HHS Office of Women's Health

- The National Indian Women's Health Steering Committee is conducting 11 surveys through Indian country to identify women's health issues and will be making recommendations to the Director of IHS.

Substance Abuse and Mental Health Services Administration

- The IHS along with other Federal Agencies are working with SAMHSA to support several Native American collaborations addressing mental health and the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence."

COLLABORATION WITH OTHER FEDERAL AGENCIES

Department of Interior/Bureau of Indian Affairs

- The IHS along with other Federal Agencies are working with the DOI/BIA to support several Native American collaborations addressing mental health, domestic violence abuse and neglect, and the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence."
- The IHS continues to work with the BIA to provide technical assistance and training for background checks of employees of tribal health programs.
- The IHS continues to be a partner in the support of the IHS/BIA Annual Youth Conference reaching Junior High and High School and college teens with an agenda that covers a wide variety of life issues.

Department of Justice

- The IHS and other federal agencies have partnered with the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention and Office of Community Oriented Policing Services to support coordinated activities in mental health and community safety for AI/AN children, youth, and families. The grant funds are for a 3-year period to provide tribes with easy-to access assistance in developing innovative strategies that focus on the mental health, behavioral, substance abuse, and community safety needs of AI/AN young people and their families
- The IHS and other federal agencies have partnered with the U.S. Department of Justice, Offices of: Tribal Justice, OJP Corrections Program and Office of Justice Program to co-sponsor the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence." The conference will focus on developing a national agenda on alcohol, substance abuse and violence for Indian country; and an opportunity for Federal agencies to highlight promising practices and strategies on alcohol, substance abuse and violence. Tribes will be given materials, and they will be able to network with researchers.

Environmental Protection Agency

- The IHS and EPA have several interagency agreements to coordinate activities of both agencies pertaining to the environment and human health of AI/AN and their lands. Through their joint effort the EPA can provide resources to the Sanitation Facilities Construction

Program's national network of staff to promote their mutual interests, create cost-efficiencies and eliminate overlapping responsibilities, i.e. design and construct wastewater treatment projects.

- In their partnership with EPA, the IHS also enters into Memorandums of Understanding (MOU) with tribes to apply and manage Clean (CW) Indian Set-Aside grants to develop and manage their water and sanitation facilities program. The IHS and EPA provide technical guidance and support throughout the process.

Federal Emergency Management Agency

- The IHS, the Federal Emergency Management Agency (FEMA) and the U. S. Fire Administration (USFA) are collaborating to reduce the rate of fire and burn injuries in American Indian and Alaska native children, ages 0-5 years to half the national average by the year 2010. Fire is the leading cause of childhood injury death in the home and children under five years of age are at the highest risk.

U.S. ARMY MEDICAL COMMAND

- The IHS and the U.S. Army Medical Command collaboration permitted the IHS to access the Army's contract with Med-National. Med-National is a health manpower recruiting firm located in San Antonio, Texas. Through Med-National, the IHS has access to an alternate source of dental manpower and has been able to place 6 dentists in IHS and tribal dental clinics.

United States Department of Agriculture

- The IHS continues to work with the USDA for WIC services for Head Start Indian children to provide basic nutrition food items to ensure health physical development of children between ages 1-5 years old.

Uniformed Services University of the Health Sciences

- The IHS also has a collaborative agreement with the Uniformed Services University of the Health Sciences (USUHS) for technical assistance in ensuring environmental compliance of IHS health care facilities. During the past year, USUHS staff developed a comprehensive hazardous materials and waste management plan that will be applied in all IHS facilities.

Department of Veterans Affairs

- Nationally, the IHS is collaborating with the VA on targeted data systems and credentialing to increase the number of Native American veterans eligible for services and to identify under-served areas of Indian country where Native Americans reside.
- The IHS, HFCA and the Social Security Administration plan to include the VA in their collaboration to develop an agreement targeting education and outreach of veteran beneficiaries who are underutilizing their benefits and services.
- Many local IHS facilities have care agreements and pharmaceutical supply agreements with nearby VA facilities that maximize capabilities and extends the outreach of services for both agencies.

- The IHS participates in the VA Drug Prime Vendor Program. By collaborating with the VA and being included on the VA prime vendor drug contract, the IHS is able to take advantage of national drug contract prices negotiated by the VA. This allows the IHS to purchase selected pharmaceutical at substantially discounted prices, even lower than Federal Supply Service (FSS) prices in most cases. The IHS has been participating for several years and plans to continue this collaboration indefinitely. The program has resulted in very substantial savings for IHS over the years.

OTHER PROGRAM COORDINATION BY SUBJECT

Obstetrics and Gynecology Training and Technical Assistance from the American College of Obstetrics and Gynecology (ACOG)

- The American College of Obstetricis and Gynecologists (ACOG) Fellows In Service Program recruits and screens Board Certified or Active Candidates for Board Certification obstetrician-gynecologists (OBG's) for short term assignments in IHS facilities. These fellows augment local IHS staff when their OBG's are away for leave, educational training, maternity leave, or prolonged illness or disability. There are approximately 8-12 assignments each year, with 11 having been assigned this past year. A number of requests have already been made for this year's program.
- The ACOG Committee on American Indian Affairs meets with IHS Headquarters, Area, and Service Unit staff 2-3 times a year and conducts an Area-wide obstetric and gynecologic quality of care consultation site visit annually. All Areas with full-service obstetrics and gynecology programs are site visited on a rotating schedule. The Billings Area was surveyed last year. The Committee met with the IHS OBG clinicians in Albuquerque in July, 2000, and is scheduling its next site visit to the Phoenix Area in the spring of 2001.
- The ACOG-IHS Postgraduate Course on Obstetric, Neonatal, and Gynecologic Care is presented annually by specially recruited and selected ACOG and IHS faculty for approximately 100-110 IHS and tribal physicians, advanced practice nurses, and clinical nurses. This course is designed to provide a week-long update of obstetric, neonatal, and gynecologic care with the focus on practices appropriate in the primary care setting in often smaller or more remote facilities. Approximately 110 have registered for the next course to be presented in Aurora, CO, in September, 2000.

Injury Prevention

The mission of the IHS Injury Prevention Program is to decrease the incidence of severe injuries and death to the lowest possible level and increase the ability of tribes to address their injury problems. The IHS has initiated an aggressive public health attack to prevent traumatic injury among American Indians and Alaska Natives. Primary emphasis is directed to the injuries of the greatest cause, such as motor vehicle crashes, and to the most common risk factors, such as lack of occupant restraints, alcohol impaired driving, and poor road conditions in rural areas. Other emphasis areas are in childhood injury, the prevention of house fire-related injuries, and building the capacity of Tribes to address injuries in local communities through core programmatic funding and training in injury prevention.

To accomplish their mission, the IHS Injury Prevention Program has formed partnerships with many government and non-government agencies. The IHS has a collaborative agreement with the National Center for Injury Prevention and Control of the CDC for the purpose of injury prevention, with specific areas of interest in injury epidemiology and surveillance and in the evaluation of community-based injury prevention and control activities. During the past year the CDC and the IHS collaborated with the American Academy of Pediatrics and several tribal groups to present the first ever briefing on injury issues to staff from the Senate Select Subcommittee on Indian Affairs.

Other formal Interagency Agreements exist between IHS and the U.S. Fire Administration, and the National Highway Traffic Safety Administration. Program staff work with many other agencies and groups including the following; the National Safe Kids Campaign, the Consumer Product Safety Commission; Bureau of Indian Affairs' Law Enforcement Services and Division of Highway Safety; American Academy of Pediatrics, Committee on Native American Child Health and the Committee on Injury and Poison Prevention; Federal Highway Administration; HRSA's Maternal & Child Health Bureau; The Johns Hopkins University; Harborview Injury Prevention Research Center; and private foundations.

1.4 Summary FY 2000 Performance Report: Accountability Through Performance Measurement

A History of Commitment to Performance

The IHS has practiced performance management and performance measurement for almost a half of a century. We have demonstrated this commitment by being pioneers in quality assurance in health care, health services resource planning, the application of information technology to health care, and the use of alternative providers and the application of the Community Oriented Primary Care approaches to health care delivery. These efforts and many others were essential to achieving the mostly unspoken and unwritten commitment adopted by most I/T/U staff to accomplish the most good (i.e., improved health), for the largest number of people, at the lowest possible cost, and in a manner that is acceptable to the consumer and the provider. As presented in Section 1.2, between 1972 and 1994, these efforts resulted in dramatic improvements in mortality rates for AI/AN population.

During our early years the results of our efforts were published as reports and journal articles from across the healthcare disciplines, often in collaboration with outside researchers and evaluators. While this collaborative approach is still used today, since 1984 the results of these efforts in terms of the health services provided, health outcomes, and other relevant demographics of AI/AN people have been annually reported in the publication *Trends in Indian Health*. In 1990 a second annual report, *Regional Differences in Indian Health*, was added to provide similar information specific to each of the 12 IHS Areas.

More recently the IHS has prepared the *IHS Accountability Report* for each fiscal year since FY 1996, which overviews health program accomplishments and management accountability and includes the annual report on the financial statement audit. While performance management and performance measurement have come a long way with the implementation of GPRA, it represents a new challenge but a familiar concept for the IHS.

Performance Summary

With this submission the IHS has reported on 26 of the 27 performance indicators for FY 1999 and 29 of its 34 performance indicators for FY 2000. The single remaining unreported indicator for FY 1999 addresses injury mortality and comes from data provided by the National Center for Health Statistics and will not be available for approximately a year. Beginning in FY 2000, this measure was changed to address injury hospitalizations to allow timelier reporting. Relative to the four diabetes related indicators not reported previously for FY 1999, analyses of the FY 1999 Diabetes Audit were released in August 1999. These findings reveal that three of the four clinical diabetes indicator targets (Indicators 2, 4 and 5) have been met and one not met (Indicator 3), based on the most recent accepted criteria for these measures. These indicators represent improvements in diabetic care that have a strong evidence based association with reduce diabetic morbidity and mortality, and will stimulate enhanced efforts to meet all diabetes treatment targets in the future. In summary, of the 26 FY 1999 indicators now reported, 18 were completely met, six partially met, and two not met (childhood immunizations and blood pressure control for diabetics).

For FY 2000, we had expected the process of compiling performance data to be more efficient and timely than our initial effort last year, but that has not been the case. Early in the process of attempting to compile reports for several indicators based on our automated patient record data

system, several global and unforeseen data problems emerged. As part of our Y2K conversion efforts in 1999, the IHS retired the obsolete IBM mainframe computing platform that was used to aggregate Indian Health Service supported health care data nationally and prepare statistical reports, which are used to report on GPRA indicators. The conversion efforts successfully addressed the Y2K date change issue but proved to be challenging when migrating existing data and duplicating the complex set of algorithms used to aggregate data from decentralized collection points. As a result some data sets could not be generated or the verification processes were not fully functional.

Intensive efforts have since been focused on procedures to reestablish the essential report generating capabilities and ultimately improve data quality. These procedures involved measures to insure that data are input consistently at service points using standardized screening edits; focusing on accuracy of coding; refining the process for aggregation and transmission; standardization of program and data definitions; and other steps required to improve the quality and completeness of data. This has been and is a challenging process requiring a high level of coordination and cooperation between the local I/T/Us, Areas and to Headquarters.

The combination of improvements in the information technology architecture and the program improvements will ultimately improve the quality and availability of data. Current efforts are focused on securing data for indicator 26 not yet reported and on final data validation and verification for six other indicators (Indicators 1, 6-8, 13 and 22). For a more detailed discussion of data validation and verification see section A.1 on page 122 in the appendix of this document. We are confident these technical set backs will be resolved in the near future and we remain committed to improving the processes for generating and making GPRA and other accountability data a major focus of our information technology development path.

From a more positive perspective, we have already realized benefits from these efforts to update and improve our data systems. Data for three indicators (i.e., Indicator 6, 7, and 27), that earlier in FY 2000 were believed to be dependent on manual assessment through chart audits, have recently been successfully extracted from our electronic patient records systems as a evaluation sample. While the completeness of the data from this process is still uncertain, we believe it represents an important further step in moving toward automated approaches of securing performance data. Based on this new capability, the chart audit originally planned as the primary approach for assessing these indicators will be used as a verification process for the electronic approach, and reported next year.

Another positive spin-off of these emerging IT capabilities is the addition of a newly proposed performance indicator for FY 2001 and FY 2002 (Indicator 17) that further expands the automated extraction of GPRA clinical performance measures by developing test sites to assess and improve data quality. Included in this innovative project are efforts to adopt recognized data standards for laboratory and other data that are now uniformly accepted by most of the healthcare industry and will be implemented within IHS in the near future. This project is also developing web-based training to support the efficient diffusion of newly developed technologies across the IHS.

Reflecting on FY 2000 overall, of the 34 performance indicators in the plan we are now reporting on 29, six of which are provisional findings pending further verification. Of these 29 indicators, 18 were achieved, nine partially achieved, and two not achieved. We will report on the remaining five indicators by this coming August. Perhaps the biggest disappointment was

not achieving the childhood immunization indicator for the second year and only achieving the dental sealant target in one age category. These are proven cost-effective public health services that we pride ourselves in the high level of coverage we maintain.

However, these findings were not all that surprising given continued difficulties in the recruitment and retention of health professionals, particularly dentists, pharmacists, and nurses. The IHS vacancy rate approached 20% for dentists during FY 2000 and continued during FY 2001 although progress has now been made in the dental category. Indeed, vacancies of this magnitude will continue to make the achievement of access-related performance measures very difficult. A detailed analysis of this problem is presented in the section that follows addressing external factors influencing success.

The other performance indicator that was not achieved for FY 2000 was Indicator 18 that addresses the diffusion of the Mental Health /Social Service automated reporting system to local programs. We believe that the major reason why no progress was made during FY 2000 was the overriding difficulties occurring in the conversion of the IHS automated data system as described previously in this section. However, for FY 2001 the IHS is implementing required automated data standards for reporting GPRA data from the Areas we and believe this requirement as well as additional marketing will expand the use of this software and also improve other data quality problems for 2001 and beyond.

Several of the process performance measures only partially achieved in FY 2000 were the result of IHS Area and Headquarters staff dealing with multiple priorities simultaneously and not being able to consistently making the GPRA requirements the highest priority. Given that many Areas and Headquarters have downsized over 50% the past few years in response to continued transition to tribal management of health programs, the level of ambient stress from conflicting demands and growing accountability requirements is a concern in adding more to people's responsibilities. However, IHS leadership has increased the visibility and priority of GPRA through a variety of venues creating an organizational awareness that GPRA is not going away but is likely to receive greater attention by OMB and Congress in the future. Furthermore, the IHS is assigning responsibilities for supporting GPRA across a broader distribution of staff with new individual performance standards. Also, by continuing to enhance the link between GPRA and the public health values we have long embraced, we will increasingly make GPRA a part of our corporate culture.

It is also worth noting that two successes in FY 2000 have resulted in our ability to set higher performance targets in FY 2001 than originally proposed. Our success in achieving a higher score in the HHS Quality of Work-life survey for FY 2000 allowed us to raise the FY 2001 target from 95 points to 97. From a public health perspective, we are pleased that our efforts in FY 2000 in improving water fluoridation compliance in pilot sites through an agreement with CDC has resulted in increased focus and earmarked funding for FY 2001. As a result all Areas will benefit from this effort and the performance target for improved access to fluoridated water in FY 2001 is expanded beyond the pilot sites to include all IHS Areas.

Probably the most important question that could be asked relative to our FY 2000 performance would be to describe what the level of accomplishment of GPRA indicators means in terms of actual improvements in health status of AI/AN people. Clearly this is a complex question that would be difficult to answer with much precision in the short run. Since many of our performance indicators deal with chronic diseases that cannot be addressed completely in the

short-term, most I/T/U public health professionals would likely be surprised if we accomplished more than holding the health status at a constant level for most conditions, with some worsening and perhaps a few improving. With the latest available mortality data (1996-1998) showing the continued increase in mortality for the AI/AN population, it is likely that the mortality disparities will not even be reversed for several years.

However, the improvements in access to critical primary services documented with the performance reports for FY 1999 and FY 2000 represent important steps in reducing the mortality and morbidity of chronic diseases. Likewise our indicators addressing prevention activities and pilot projects offer the potential to ultimately reduce the prevalence of these same chronic diseases. Making significant strides in reducing the health disparities in the AI/AN population will require continued improvements in access to treatment and preventive services to be sustained for many years as well as addressing the related problems of unemployment and poverty. These issues are discussed in the next section of this document.

Despite these challenges, the implementation of GPRA in the IHS has resulted in some continued benefits that are likely to contribute to future success. First, the GPRA/Budget Formulation process has increased collaboration and understanding of public health and budgeting across the diverse IHS stakeholders. The process of addressing these issues beginning at the local level and moving up has aligned and mobilized tribal leaders and consumers about funding issues that address significant public health problems. In this process health program staff have learned more about the IHS budget process and budget/finance staff have learned more about public health. But probably of most importance, tribal leaders and consumers have had the opportunity to have dialogue about the "big picture" of Indian health and learn more about both public health and budgeting.

This new knowledge appears to have resulted in improved cooperation across the diverse I/T/U network. As a result, I/T/U leaders are using this knowledge to speak with less parochial and more unified voices supported by data, to justify funding requests. Furthermore, a growing number of tribally managed programs that legally do not have to participate in GPRA are not only participating, but also encouraging other tribal programs to do likewise. A notable example of Tribal collaboration and participation in GPRA related activities is the partnership between the Nashville Area Office and its Tribes. The Area works closely with the United South and Eastern Tribes, Inc. (USET), which represents most of the Tribes in the Area. USET has identified 13 Tribal Health Objectives and chartered a Health Indicator Review Committee to review and refine this set of health indicators that each Tribe is recommended to monitor and report progress on. The Health Indicator Review Committee consists of Tribal health personnel and Area Office epidemiology, public health and environmental health staff. All USET Tribes have elected to participate in this project.

The Tribes have further demonstrated their commitment to this activity through their cooperation in providing key Area staff access to their data systems. The Nashville Area epidemiologist has established a mutually cooperative relationship with the Tribes that has improved the collation and validation process for assessing progress towards the national and Tribal indicators. This level of partnership is a noteworthy example of Tribal commitment and involvement in using health indicators to improve the health status of AI/AN people.

As a final reflection on FY 2000, the IHS is indebted to *Joe DeLaCruz* for his efforts in encouraging and assisting tribes in participating in the GPRA process. His untimely passing in

April 2000 was a loss to all AI/AN people and the organizations that support them. Our dedication of this submission in his memory is a tribute to his life-long commitment to the health and well being of the AI/AN people.

Key External Factors Influencing Success

A variety of external factors have functioned as powerful determinants in the level of attainment of the FY 2000 Performance Report and will continue to influence our success in future performance reports. It is important to acknowledge that for many of these factors the distinction between what is external versus internal is often blurred. However, making this distinction is a critical element in successfully addressing them.

Recruitment and Retention of Health Care Providers

As acknowledged in the previous section, vacancy rates for some health care providers are at the highest level in IHS' history and are directly related to difficulties in both the recruitment and retention of these providers. The reasons for these recruitment and retention difficulties are complex and include both external factors as well as factors within the I/T/U settings. The broader external factors are the growing debt levels for health professionals leaving school, coupled with increasing earning potential in the private sector as a result of a healthy economy and relative shortages of these health professionals. The factors within the IHS context include relatively poor salary parity between the Federal systems and the private sector, isolation and a lack of urban amenities in many reservation settings. Furthermore, limited spousal employment opportunities, ancillary support, and clinical space to address an ever-increasing patient load, have also contributed to recruitment and retention difficulties.

These local factors have been compounded by diminished professional support to IHS managed programs because of downsized Areas and Headquarters that has occurred in response the continued transition to tribal management of health programs. While this Area and Headquarters downsizing was a planned part of the self-determination process, it resulted in a loss of economies of scale greater than expected.

Collectively these trends and associated reductions in career development and training opportunities have appear to have resulted in a decrease in morale of IHS providers. Objective indicators for this trend include the relatively low score of the IHS in the 1998 and 1999 HHS surveys that define the Human Resource Management Index from the Department as a whole and for each OPDIV. This annual process is based on a survey of a sample of employees from each HHS agency and has been designed to assess several recognized components of the "quality of work life." While we are pleased to report that the IHS score for this survey did improve for FY 2000, the IHS score still remains below the Department average. Clearly a sustained effort will be needed to meet the performance targets for FY 2001 and FY 2002.

Lastly, there has been a significant increase in EEO filed complaints across over the past few years within the IHS. While this trend is undoubtedly the result of many factors, it is likely that staff morale and the stresses of downsizing have been contributing factors. Thus, the net effect of these trends is to compound the retention problem because the staff are affected by diminished support and overwhelmed by the patient load. For consumers, the waiting times for appointments increase and complaint rates increase. This can result in staff becoming discouraged and resigning as well as patients giving up trying to access the system for health

care needs except emergencies. In effect, patients may not proactively seek services such as well-baby, cancer screening, dental care, or diabetes control.

The IHS is committed to improving its performance in the recruitment and retention of well-qualified health care providers and the FY 2000 -2002 Budget Requests and Performance Plans strategically address this problem. Activities directed towards this end include:

- expanding web-based recruiting efforts
- expanding consideration of alternative Federal pay structures to address pay parity issues
- expanding the loan repayment program and making it more flexible for I/T/U use
- developing alternative mechanisms to support health disciplines in partnership with tribes and tribal organizations including the addition of two Tribal Epidemiology Centers and four Dental Clinical and Preventive Support Centers
- continuing efforts to enhance quality of work life (QWL) through greater adoption of HHS QWL policies and enhanced leadership training

The Role of Poverty

The relationship between poverty and higher levels of morbidity and mortality for both acute and chronic diseases and conditions has been documented worldwide. In fact, many of the racial and ethnic disparities in health status disappear when analyses control for education and socioeconomic status. Across Indian Country, mortality and morbidity rates generally follow the general economic indicators such as socioeconomic status, employment rate, and also educational level. As noted in the introduction of this document, the IHS serves several of the poorest communities in the country that also have the lowest life expectancy rates.

While increasing access to comprehensive health services over time will reduce both mortality and morbidity to some degree in these situations, health services alone are not likely to eliminate the huge health disparity gap that now exists, unless the other complex factors contributing to poverty are also addressed. However, it must be acknowledged that the current challenges associated with access to many essential services are contributing not only to poor health but also to poor economic conditions. Indeed, poor health status should be viewed as both a cause and an effect of poverty.

We offer an example of how powerful even relatively mundane and non life-threatening health problems can be when they reach extreme levels. Between 1988 and 1991 the IHS Dental Program participated in the World Health Organization sponsored International Collaborative Study of Oral Health Outcomes. Data were collected on the Lakota Sioux Indian people on the Pine Ridge and Rosebud Reservations in South Dakota and on Navajo people in the northeast corner of the Navajo reservation in Arizona and New Mexico. Other study sites include Baltimore and San Antonio in the United States and Latvia, France, New Zealand, and Japan. The study included calibrated and standardized oral examinations with assessments of disease rates and treatment needs and a detailed patient interview that included a history of dental experiences and problems.

The oral health examination corroborated findings from IHS surveys that the oral conditions of Navajo and Lakota Indian people were very poor with disease rates two to four times that of all other study sites. Findings from the studies patient interview that assessed the impact of oral health on a variety of quality of life measures revealed the following alarming findings:

- one third of school children report missing school because of dental pain.

- 25% of school children avoid laughing or smiling and 20% avoid meeting other people because of the way their teeth look.
- as a consequence of dental pain, almost a quarter of the adults are unable to chew hard foods, almost 20% report difficulty sleeping, and 15% limit their activities (i.e., work and leisure).
- three quarters of the elderly experience dental symptoms, and half perceive their dental health is poor, or very poor and are unable to chew hard food.
- almost half of the adults avoid laughing, smiling, and conversations with others because of the way their teeth look.

These "quality of life measures" were 200 to 400 % more severe for the Indian study respondents than those from any other sites including Baltimore and San Antonio. Clearly, conditions of this magnitude represent significant disparities in health status and are not just dental problems, but have significant social, psychological, and economic consequences on peoples' self-esteem and their ability to learn, secure employment, and reach their full potential. When such dental conditions are superimposed on top of other prevalent conditions normally considered far more severe such as diabetes, alcoholism, and family violence, a person's capability to achieve self-sufficiency is seriously compromised.

There is little doubt that in many AI/AN communities health status is contributing to the economic hardship they experience. It is also true that improved health care alone cannot make up for the lack of opportunities for economic development. Some tribes are making significant progress in this process and many of these are the ones who have exercised their option under the Indian Self-Determination legislation to manage their own health programs. While the IHS is not an economic development organization, we are committed to assuring that our available resources are used effectively to minimize the negative effects of poor health status on the general socioeconomic well being of AI/AN communities. Furthermore we are working to collaborate with the BIA, the Administration for Native Americans, and with other organizations with the capacity to assist in economic development. Our success in improving the health status of the AI/AN population in this century will continue to be strongly influenced by the overall success of efforts to address poverty in Indian Country.

A Lack of Cost-Effective Interventions for Chronic Diseases

A major challenge the IHS must address is how to provide health care in the face of increasing mortality and morbidity rates for diseases such as alcoholism, diabetes, and cancer that represent extremely costly conditions to treat. Of these problems, perhaps diabetes represents the greatest economic challenge to the IHS. Within the I/T/U system are communities with the highest diabetes prevalence in the world with many other communities showing accelerating increases annually. Although we are collaborating with CDC and the University of New Mexico to develop preventive approaches, at this point in time, there are no proven large-scale educational or medical interventions known to reduce the prevalence of this condition in populations.

Until a preventive technology is developed, we are faced with the costly medical management of diabetics that is currently estimated in the diabetes literature at \$5000 to \$9000 per patient per year. The IHS is funded at approximately \$1400 per person per year with Medicare/Medicaid, private insurance collections and out of pocket expenditures adding an estimated \$500-700 more. Thus, AI/AN people are funded at approximately \$2000 per person annually compared to almost \$4000 for the U.S. general population. In communities where the diabetes prevalence is approaching 40-50 percent, the entire available per capita funding could be completely

consumed in treating diabetes, leaving nothing for alcoholism, cancer, injuries, oral health, prenatal care, and well-baby/immunizations to name only a few.

Given these economic realities, the I/T/Us are faced with difficult choices in assuring access to essential health care. While there are always ways to improve efficiency and effectiveness and "do more with less," at least in this country, there are no private or public health systems that have set more cost-effective benchmarks for effectively addressing diseases problems of this magnitude than the IHS. It appears decidedly easier to show a profit in the health care industry than to improve the health of the poorer segments of the population. We contend that since our inception in 1955 to the early 1990s, the IHS has set the benchmarks for rural health care efficiency and effectiveness.

Clearly our long-term success in improving the health of the AI/AN population will be strongly influenced by the development of major cost-effective treatment and/or preventive technologies for addressing the many health conditions AI/AN people experience at high rates.

Third Party Collections

The IHS has established a priority to identify any available alternate resources and fully maximize third party collections for delivery of health care services. This priority was established in recognition that increasing collections is a critical element to maintaining and improving the delivery of health services to the IHS service population. Over the last few years the IHS has significantly increased its third party collections, as a result of higher negotiated Medicare and Medicaid rates, new authority to bill under CHIP and more efficient business management practices, involving patient eligibility determination, documentation of services and processing of claims. These increases have been critical to the I/T/U's ability to meet increasingly demanding accreditation and quality standards and maintain access to services in the face of growing health demands driven by population growth and increasing health disparities.

Specific to GPRA, third-party collections clearly contribute to many performance measures and are considered in a general way in setting performance targets. However, it is difficult to link collections to specific GPRA indicators in a quantified way for several reasons. First, unlike our budget authority that is specifically identified each year, we can only estimate our collections. We are able to do this with some accuracy because we do have previous year's collection amounts for all but a few freestanding tribally operated facilities. Our data on how these funds are actually used is considerably less specific. We do not have data on how collections are used by tribal programs because they are not required to provide it. Secondly, within the direct care settings our accounting system only identifies how collection are used at the object class level and this data is included IHS budget justifications each year (see page 72 of the FY2001 Congressional budget justifications). As a result, with our existing accounting capabilities there is no practical way to show for which funding categories or indicators these collections are being used in the many diverse IHS settings. Therefore capturing of such information with our current systems would be impractical and not cost-effective in the context of GPRA or sound public health practices.

The strongest link between these collections and a specific performance measure is Indicator 21 that addresses maintaining the accreditation of health care facilities. First priority for use of collections is directed to funding activities necessary to maintain JCAHO accreditation standards, including specific compliance with deficiencies documented during JCAHO/HCFAs surveys. As a result, specific use of collections to meet accreditation standards varies widely

across our health care facilities. In some cases these funds are used to support health care staff positions and others to support building maintenance and compliance with life safety codes. In terms of the four broad budget aggregation categories our performance plan and indicators are based on (see page 39), a crude estimate for how these funds are directed would be 85 percent into the "Treatment" aggregation and 15 percent into the "Capital Programming/Infrastructure" aggregation. We have included estimated collections levels in the summary tables for these two aggregation categories (see pages 49 and 104).

We are encouraged that IHS and HCFA have been working in collaboration under a Joint IHS/HCFA Steering Committee to address major policy issues that improve the delivery of services to IHS populations who have Medicare and Medicaid eligibility. Many of the issues that have been addressed and that are being addressed by the Joint Steering Committee have some impact on IHS' ability to achieve the above objective of optimizing maximizing third party collections. For example, joint efforts to develop cost reports contribute to ensuring that IHS receives a fair reimbursement for its services.

Most recently, the IHS/HCFA Steering Committee have focused on developing a plan to implement the recently enacted legislation that authorizes the IHS under Part B to bill and collect for physician services provided to Medicare beneficiaries. Indeed, maximizing third-party collection will remain a critical activity in the achievement of the IHS Mission.

Transitions to Tribal Management

The rate of transition to tribal management of health programs has and will continue to represent a significant challenge to the IHS. This transition toward tribal management of health programs has required Area Offices and Headquarters to downsize significantly. While this was a planned part of the Self-Determination process, an unfortunate side effect of this downsizing has been the loss economies of scale and reductions in the IHS public health infrastructure. We are encouraged by this growing trend of growing tribal management of critical public health infrastructure including Tribal Epidemiology Centers and Dental Clinical and Preventive Support Centers.

There is also evidence that the transfer of resources and management control to tribes has freed them to innovate, develop alternative resources, find new mechanisms for building facilities, and enhance patient care, which ultimately will improve outcomes. What is still not completely clear at this time is at what level tribal programs will participate in GPRA performance measurement, given that it is voluntary based on current regulations. While a growing number of tribal programs have expressed a commitment to submit data for GPRA in response to our active marketing of its importance, some have expressed resistance based on a belief that it represents an optional administrative activity that diverts resources away from patient care. Indeed the IHS is in a challenging position with the responsibility of including tribal programs in performance reporting, but lacking the authority to require tribes to submit their data. Despite these challenges the IHS remains committed to tribal self-determination and to performance management and views both as essential to the realization of our Mission and Goal.

PART II - PROGRAM PLANNING AND ASSESMENT

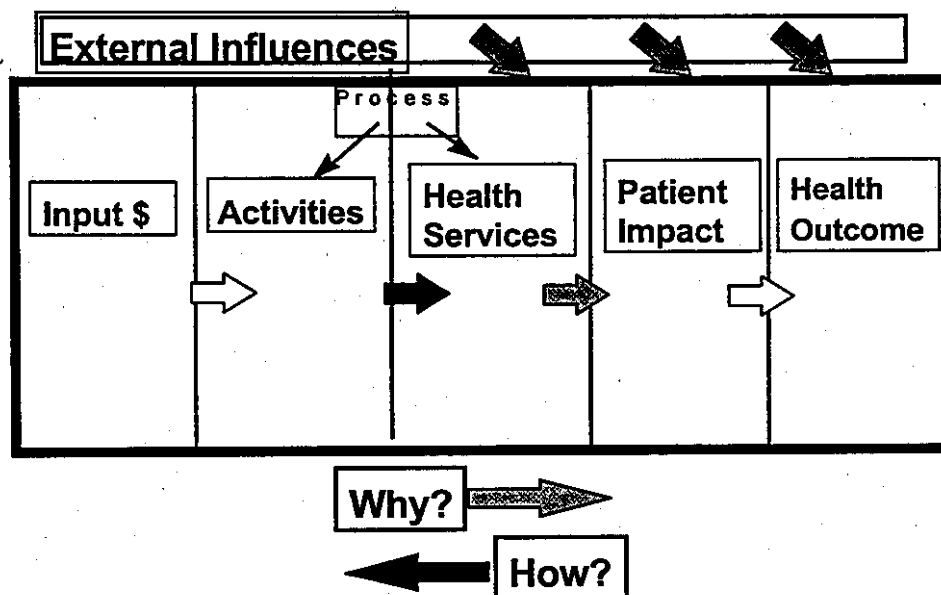
It must be borne in mind that the tragedy of life doesn't lie in not reaching your goal. The tragedy lies in having no goal to reach. It isn't calamity to die with dreams unfulfilled, but it is a calamity not to dream. It is not a disaster to be unable to capture your ideal, but it is a disaster to have no ideal to capture. It is not a disgrace not to reach the stars, but it is a disgrace to have no star to reach for. Not failure, but low aim is sin.

Benjamin Mays

Introduction and Rationale

The diagram that follows has been used the past three years to explain the GPRA process and shows that it is essentially the same as the public health approach the IHS has long followed in health planning and evaluation. The logic of this model links resources to activities or "process" (both support and direct health services) which leads to reductions in risk factors for diseases and conditions (i.e., impact) and over an extended period of time results in improved health outcomes. The model also depicts how external influences such as economic status (see Section 1.4, *The Role of Poverty*) isolation, or social norms can have powerful effects on the success of interventions, particularly in addressing lifestyle related health outcomes.

The Public Health/GPRA Approach



In light of this conceptual model, three broad categories of indicators are of relevance.

Process Indicators:

Indicators that assess the quantity or quality of activities that have the potential to contribute, at least indirectly, to reduced mortality or morbidity in the population over time.

Process indicators include activities such as the construction of clinics, identification of the prevalence of a disease or condition, implementation of consumer satisfaction surveys, and the provision of some health services (i.e., services for which the link to improved health

outcomes has not been consistently demonstrated). These are important activities that may be essential to running an effective health care program, but do not in and of themselves result in improved health outcomes. The GPRA represents a process requirement, and committing to comply with these requirements represents a process indicator. (See Activities and Health Services boxes in diagram)

Impact Indicators:

These are indicators that assess the quantity or quality of activities that have a scientific evidenced-based link to improved health outcomes usually by a demonstrated reduction in a recognized risk factor of mortality or morbidity in a population. These indicators are referred to as "interim outcomes" in much of the GPRA literature. They include activities such as immunizations, dental sealants, assuring safe drinking water, and cancer screenings. Over time these activities result in improved morbidity and/or mortality. Impact indicators are usually the most appropriate type of indicator for annual performance plans because they provide the most measurable link between funding and results. (see Patient Impact box in diagram)

Outcome Indicators:

These are indicators directly relate to reducing mortality or morbidity relative to a disease or condition that program(s) address. While these indicators are the ultimate goal of health care, for many health conditions it is often years before outcome benefits are realized. Furthermore, identifying the cost of an observed outcome is often difficult or impossible in the cases of conditions that multiple providers may be addressing simultaneously while addressing other health conditions. Thus, outcome indicators are usually not the most appropriate choice for annual performance plans, but are essential to identify for long-term goals such as in the GPRA Strategic Plan. Examples include reducing the prevalence of obesity, diabetic complications or reducing the unintentional injury mortality rate (see Health Outcome box in diagram).

It is appropriate to note that general workload types of indicators such as total outpatient visits and inpatient days are not included in this performance plan because any meaningful link to health outcomes is indirect or circuitous, at best. As noted earlier, outpatient visits have grown with population growth rather than varied with level of funding. Inpatient days have been declining across the country as well as in the I/T/U care systems to control costs and neither of these measures have shown an interpretable correlation with improved health status. However, these data will continue to be monitored and presented to the Department as part of the IHS annual accountability report because they are of significance in the context of expenditures and demands on the I/T/U system.

The IHS performance indicators represent sentinel indicators that are specifically focused on the most significant health problems affecting AI/ANs and/or the essential services that address them and identified by local I/T/Us. These problems include: diabetes, alcohol and substance abuse, cancer, dental diseases, mental health, heart disease, family abuse and violence, injuries, poor living environment, mental health, tobacco use, obesity, environmental hazards, and the unique health problems of elders, women and children. They all represent important links in the

GPRA/public health process directed towards outcomes. Some represent primary prevention that attempts to prevent a disease or condition before it occurs (e.g., immunizations or controlling weight to prevent heart disease or diabetes). Others are "secondary preventive" in nature in that

they attempt to reduce the morbidity and mortality associated with a disease or condition after it has occurred (e.g., access to dental care or breast cancer screening). Given that there will always be ten leading causes of death, our focus is to intervene early in the processes that contribute significantly to mortality and morbidity, rather than to target end point problems such as heart attacks and stroke. This is the essence of the cost-effective public health approach that has resulted in the improvements in health status of AI/AN people over the last three decades.

We have also included indicators for improving how our consumers perceive the quality of and access to services, how employees perceive the quality of their work-life, and how our stakeholders perceive our performance in assuring adequate consultation and advocating for their needs. In addition, several indicators address expanding our information technology capacity to improve health care delivery and performance management.

The indicators in this plan do not represent the complete spectrum of activities and challenges the Agency and the I/T/Us address as part of a comprehensive public health organization. To do so would probably require several hundred indicators and require significant increases in resources just to collect the data. Consistent with the proposed GAO guidance, these indicators are limited to a vital few, represent multiple priorities, are linked to the responsible programs, and in many cases are measures we have used for many years for program evaluation. Several are focused primarily on better defining the magnitude of certain problems and improving our evaluation capability.

A major challenge in selecting indicators for a one-year plan is that many of the processes necessary for intervening in complex chronic diseases require years or decades of focused efforts to realize significant progress, even with significant resource enhancements. Therefore, only a few of these indicators directly address health outcomes, while most are incremental activities that will lead to such outcomes over time. Finally, all health-problem related indicators support the HHS HP 2010 goals, and all indicators and the entire plan support the Department's recently revised Strategic Plan.

However, these indicators were developed in partnership with Area and I/T/U staff and AI/AN tribal leaders with the first priority being the need to reflect the problems and strategic activities of the I/T/Us collectively. We believe this approach is essential to secure the high level of collective support we will need with our diverse and decentralized programs. Because of the diversity across I/T/Us and the freedom of tribal programs to participate in GPRA activities at their discretion, not all indicators will be of priority to all I/T/Us. Furthermore, there are activities that are not included in these indicators that will continue to be priorities, particularly health issues unique to local I/T/Us.

Application of the Balanced Scorecard Conceptual Model to Health Performance Measures

The IHS has elected to incorporate a modification of the Balanced Scorecard conceptual model as an additional classification of each indicator under the subheading "Type of Indicator." Based on this model originally proposed by Robert Kaplan and David Norton in their seminal article in the *Harvard Business Review* in 1992, it is essential for each company to address performance measurement by answering four basic questions:

1. How do customers see us (customer perspective)?
2. What must we excel at (internal perspective)?
3. Can we continue to improve and create value (innovation and learning perspective)?

4. How do we look to shareholders (financial perspective)?

While this model was designed to fit the context of profit-oriented companies, we contend that with slight modification it has significant utility in a Federal agency such as the IHS. Clearly the first question has relevance for the IHS as a health care organization. The IHS Goal, presented on page six, addresses the availability and acceptability of culturally acceptable health services. Indicator 21 relates to a consumer satisfaction survey designed to capture the critical elements of health care consumer satisfaction that have been identified in the related literature. Additionally, Indicator 37 assesses I/T/U stakeholders (internal customers) satisfaction with the consultation process relative to budget and policy issues.

The second question targets the critical internal capabilities that are essential to meeting customer demands as well as the long-range mission-critical operations of an organization. For the IHS this clearly relates to our ability to efficiently and effectively provide comprehensive health services that many of our indicators are based on. In addition, it is critical that we also address support functions such as securing health care and health status data, building and maintaining facilities, and developing appropriate management structures. Thus, the majority of indicators in this plan address this question.

The third question addresses our ability to learn and grow as an organization and has tremendous significance for the IHS because some of the health problems we face have yet to be solved anywhere in the world in a public health setting. Thus, indicators that pilot new technologies and approaches to such problems as childhood obesity and diabetes (Indicator 29) represents field research and intervention technology development. Similarly, indicators addressing suicide prevention, personal and organizational fitness, and tobacco control represent learning and applying technologies proven effective from other settings to the unique environments across Indian Country (applications research).

The final question relates to financial success or profitability and in essence is a look back at how the business has worked in the past. On the surface the notion of profitability is perhaps more difficult to apply to a Federal public health agency such as the IHS, since profit is not part of our focus. However, we would contend that the analogous currency of profitability to a public health organization would be improvements in the health status of the served population brought about by the efficient and effective delivery of high quality health care. In this context public health profitability is a look back at what has been accomplished in terms of improving health status and an analysis of the cost and relative productivity in providing services.

It is worth noting that this view of "public health profitability" is virtually the same construct as the Public Health/GPRA Approach outlined earlier in this section, or more globally, the essence of GPRA itself for public health. As will be pointed out several times in this plan, it is often not possible to show "public health profitability" in a one-year period when dealing with chronic diseases. Therefore few indicators in this plan address the outcome issue, but focus on reducing the risk factors as describe earlier in the description of "impact indicators."

The utility of applying the Balanced Scorecard in the context of planning and evaluation in the IHS is similar to the benefits realized in the private sector. It guides our focus to not only look back on what we have accomplished, how our consumers feel about it, and to determine what things to continue, but also where we need to move in the future and what capabilities we must develop or purchase to get there. Perhaps this process of finding the ideal balance in making

future resource decisions is the most challenging part of public health. Investing in "potential" versus the "proven" is usually a risky process but the use of the Balanced Scorecard can assist in making such decisions consciously with the best available information. Over time, we believe the use of Balanced Scorecard can enhance the effectiveness of our GPRA process.

Budget and Program Aggregation

Because of the number and diversity of IHS health programs, these activities can be organized in many different ways. Our goal in presenting our performance measures is to relate to the best of our ability, performance to our budget. This is a serious challenge to the IHS for several reasons we will articulate. We have selected an aggregation approach largely based on the way our programs are managed and have selected four functional areas for the aggregation of the 24 budget categories identified in the IHS "Detail of Change Table": 1.) Treatment, 2.) Prevention, 3.) Capital Programming/Infrastructure, and 4.) Consultation, Partnerships, Core Functions, and Advocacy. While this approach may appear to be an overly simplistic "lumping" of categories, it is important to realize that there is no aggregation or disaggregation that allows mutually exclusive activities linked to mutually exclusive health problems.

This conundrum exists because addressing most chronic diseases and problems such as diabetes, injuries, and family violence requires multidisciplinary interventions to be successful. In such cases, there may be several health programs (and thus funding categories) simultaneously addressing a health problem such as diabetes. Confounding the issue further, these same diverse providers may be addressing other health issues such as tobacco use, blood pressure control, or mental health during the same encounter. Lastly, tribal programs, which now manage over 40% of the total IHS budget, have the legal flexibility to reprogram funding categories to meet their identified health priorities and likewise use an accounting tailored to their needs and preferences. As a result, with the exception of the facilities construction category, tribes tend to use resources based on individual tribal priorities and the link between named categories in the IHS budget and how the funds are actually used in tribal programs may not be highly correlated.

Thus, for tribal programs the aggregation issue is probably moot. For IHS managed programs, aggregation of budget categories that not only splits out activities and funding sources but also allows a valid cost accounting link to health outcomes cannot be provided. In such cases, the accounting link can go no farther than services. A manufacturing type of accounting mindset taken to an extreme simply does not fit well in the context of a comprehensive public health program. Therefore, the aggregation approach we have selected seems reasonable given the limitations of any approach and that we do have the option to disaggregate these inputs if desired for a more narrowly focused look at well circumscribed programs such as dental services or public health nursing.

There is no priority order to these categories and all are important in accomplishing the mission of the IHS. Chart II that follows shows the relationship between the funding categories in IHS Detail of Change Table and the appendix of the "Budget of the United States" and our GPRA aggregation. A brief explanation of the components of each aggregation category precedes each set of performance indicators.

Chart II

Budget Category Aggregation

<u>INDIAN HEALTH SERVICE</u>	<u>APPENDIX</u> Budget of the United States items from left column	<u>GPRA AGGREGATION</u> items from left column
Detail of Change Table		
<u>SERVICES:</u> 1 Hospitals & Health Clinics 2 Dental Services 3 Mental Health 4 Alcohol & Substance Abuse 5 Contract Health Services Total, Clinical Services 6 Public Health Nursing 7 Health Education 8 Comm. Health Reps 9 Immunization AK Total, Prev Hlth 10 Urban Health 11 Indian Health Professions 12 Tribal Management 13 Direct Operations 14 Self Governance 15 Contract Support Costs Total, Services	<u>SERVICES:</u> 1 Clinical Services (1-5) 2 Preventive Health (6-9) 3 Urban Health (10) 4 Indian Health Professions (11) 5 Tribal Management (12) 6 Direct Operations (13) 7 Self Governance (14) 8 Contract Support Costs (15) Total, Services	1. Treatment (1,2,3,4,5,10,11,12,14,15) 2. Prevention (6,7,8,9,19b)* 3. Capital Programming/ Infrastructure (16-20)** 4. Partnerships, Consultation, Core Functions, and Advocacy (13,19a-c)*** *The Prevention category includes 35% of Environmental Health Support (19b) activities. **The Capital Programming/Infrastructure category includes 80% of Facilities Support (19a), 60% of Environmental Health Support (19b), and 20% of OEHE Support (19c) activities. ***The Partnerships, Consultation, Core Functions, and Advocacy category includes 20% of Facilities Support (19a), 5% of Environmental Health Support (19b), and 80% of OEHE Support (19c) activities.
<u>FACILITIES:</u> 16 Maint. & Improvement 17 Sanit. Facil. Constr. 18 Hlth Care Facs. Constr. 19 Facil. & Envir. Hlth Sup 19a Fac. Support 19b Env. Health Support 19c OEHE Support 20 Equipment	<u>FACILITIES:</u> 9 Maint. & Improvement (16) 10 Hlth Care Facs. Constr. (17-18) 11 Facil. & Envir. Hlth Sup (19a-c) 12 Equipment (20)	
Total, Facilities	Total, Facilities	
(20) Total, IHS	(12) Total, IHS	(4) Total, IHS

**Budget Category Aggregation
Crosswalk to FY 2002 Budget Request**

	Category/Sub-sub activity	FY 2002 Request
	TREATMENT	
1	Hospitals & Health Clinics	1,137,711,000
2	Dental Services	95,305,000
3	Mental Health	47,142,000
4	Alcohol and Substance Abuse	135,005,000
5	Contract Health Services	445,776,000
10	Urban Health	29,947,000
11	Indian Health Professions	30,565,000
12	Tribal Management	2,406,000
14	Self-Governance	9,876,000
15	Contract Support Costs	288,234,000
	M/M and PI Collections (85%)	424,987,000
	Diabetes	100,000,000
	Total	\$2,746,954,000
	PREVENTION	
6	Public Health Nursing	37,781,000
7	Health Education	10,628,000
8	Community Health Representatives	49,789,000
9	Immunization AK	1,526,000
19b	Environmental Health Support (35%)	18,500,000
	Total	\$118,224,000
	CAPITAL PROGRAMMING/ INFRASTRUCTURE	
16	Maintenance & Improvement	45,331,000
17	Sanitation Facilities	93,827,000
18	Health Care Facilities Construction	37,568,000
19a	Facilities Support (80%)	50,426,000
19b	Environmental Health Support (60%)	31,713,000
19c	OEHE Support (20%)	2,177,000
20	Equipment	16,294,000
	M/M and PI Collections (15%)	74,998,000
	Quarters	4,700,000
	Total	\$357,034,000
	PARTNERSHIPS, CONSULTATION, CORE FUNCTIONS, AND ADVOCACY	
13	Direct Operations	65,323,000
19a	Facilities Support (20%)	12,606,000
19b	Environmental Health Support (5%)	2,643,000
19c	OEHE Support (80%)	8,710,000
	Total	\$89,282,000

2.1.1 Treatment and Prevention Categories: Program Description, Context and Summary of Performance

Program Description and Context

Treatment and Prevention indicators have been combined in this section for several reasons including:

- the distinction between treatment and prevention is often blurred
- many health care programs provide both kinds of services
- approximately 90% of IHS resources are directed towards these activities
- monitoring for both is usually accomplished from the same data systems

In essence, prevention and treatment are our business and virtually all other activities are supportive to them. Combined they are the essence of IHS Strategic Objective 2: Provide Health Services and the means to accomplishing our Mission and Goal and IHS Strategic Objective 1: Improve Health Status. The indicators directly address the structure, process, and outcome of treatment and preventive services. While some of these measures such as the dental indicators 12 -15 and public health nursing indicator 22 can be closely linked to the funding request, most are less directly evident in their linkage to funding because they represent activities performed by staff from multiple disciplines who address multiple health problems. For a more detailed discussion of the limitations in funding linkages with indicators, see *Budget and Program Aggregation* on page 38 and Section A.4 on page 133 in the appendix of this document.

Ultimately, our performance in treatment and prevention activities will determine our level of success in improving the health of the AI/AN population. But setting one-year performance targets linked to funding is not a precise science. While we are on track to accomplish many of the treatment and prevention targets for FY 2001, several remain in question because of the growing difficulties in recruitment and retention of critical health care providers. Our ability to recruit additional health care providers and having the needed clinical space available to utilize them efficiently may not be realized in a single year. In some cases, investments in the supportive infrastructure are the highest priority for long-term effectiveness but will do contribute no measurable benefit in the short-run to increase access to services.

It is also important to keep in mind in reviewing performance indicators and performance results that the AI/AN population increases over two percent annually. Thus, service capacity must be increased over two percent just to remain at the same level of coverage each year for the indicators that set a target for the percent of the population covered.

For a more detailed discussion of the issues influencing performance accomplishment see the *FY 1999 Performance Summary* section beginning on page 24. In addition, a performance summary table precedes each section of indicators and the description of each individual indicator includes an assessment of estimated performance achievement for FY 2000. The budget category/programs that make up the Treatment and Prevention categories, along with their page reference in the budget are presented on the following page:

Treatment Aggregation

Hospitals and Clinics - supports inpatient and ambulatory care and support services such as nursing, pharmacy, laboratory, nutrition, medical records, etc (see page IHS-27 in FY 2002 budget document).

Dental Services - supports the provision of dental care through clinic based treatment and prevention services and community oral health promotion and disease prevention activities including water fluoridation and dental sealants (see page IHS-37 in FY 2002 budget document).

Mental Health - supports community oriented clinical and preventive mental health and social services programs (see page IHS-43 in FY 2002 budget document).

Alcohol and Substance Abuse - supports the efforts of tribes in the provision of holistic alcoholism and other drug dependency treatment, rehabilitation, and preventive services for individuals and families (see page IHS-51 in FY 2002 budget document).

Urban Indian Health - supports contracts and grants to 34 urban health programs funded under Title V of the Indian Health Care improvement Act (see page IHS-93 in FY 2002 budget document).

Indian Health Professions - supports self-determination and access to health care through efforts to enable AI/AN to enter health professions, and effective recruitment of health staff by providing scholarships, loan repayment, temporary employment, and health professions recruitment (see page IHS-99 in FY 2002 budget document).

Self-Governance - supports the Office of Tribal Self-Governance and Self-Governance Planning and Negotiating grants. (see page IHS-115 in FY 2002 budget document).

Contract Support - provides administrative costs for tribal managed programs in addition to what would have been provided under the direct provision of the program as authorized under Section 106(a) (2) of P.L. 93-638, the Indian Self-Determination Act, as amended (see page IHS-125 in FY 2002 budget document).

Prevention Aggregation

Public Health Nursing - supports the community-based Public Health Nursing program which provides treatment, counseling, health education, and referral activities carried out in such setting as homes, schools, jails, bars, and community centers in conjunction with a diversity of other health care providers (see page IHS-73 in FY 2002 budget document).

Health Education - supports activities directed towards promoting healthy lifestyles, community capacity building, and the appropriate use of health services through public health education targeted at school health, employee health promotion, community health, and patient education (see page IHS-77 in FY 2002 budget document).

Community Health Representative - supports the tribally administered program of training AI/AN community members in basic disease control and prevention. These activities include

serving as outreach workers with the knowledge and cultural sensitivity to effect change in community acceptance and utilization of health care resources and use community-based networks to enhance health promotion/disease prevention activities (see page IHS-81 in FY 2002 budget document).

Alaska Immunization Program - supports the Alaska immunizations program to address hepatitis and haemophilous influenzae through collaboration with the CDC (see page IHS-85 in FY 2002 budget document).

Environmental Health Support - supports the IHS injury prevention program that coordinates and provides grants for primary preventive community-based collaborative programs using epidemiologically defined problem identification and evaluation methods (see page IHS-39 in FY 2002 budget document).

2.1.2 Treatment and Prevention: Performance Indicators

The choice of these indicators was made after considerable deliberation and "trial and error" over the past three years that has resulted in the acceptance of several selection criteria:

- they address major functional areas of our budget structure (i.e., major health programs)
- they represent I/T/U priority areas in terms of addressing health problems
- they are relatively passive to I/T/U providers in that they are extracted from existing data systems and do not add to their workload
- they do not reward under reporting of conditions (i.e., reducing complication of diabetes was dropped for this reason)
- they are evidenced-based and support recognized standards of care

While not all treatment and prevention indicators measure up to all these criteria, most come close. It is important to acknowledge that for many indicators, a measurable change in the ultimate outcome is not likely to be seen in the one-year time span of the performance plan. Similarly, the target levels that can be accomplished for many treatment and prevention indicators may not be related to funding levels in a simple linear relationship in a one-year period. Recruiting additional health care providers coupled with securing the needed clinical space to utilize them efficiently many require several years before significant improvements to access are realized. In some cases, investments in the supportive infrastructure are the highest priority for long-term effectiveness but will do little in the short-run to increase access to services.

The data that support the treatment and prevention indicators comes from several sources but the largest number are extracted from the IHS automated information system which collects data on the services provided by IHS and tribal direct and contract programs. In addition, the diabetes treatment indicators 2-5 are extracted from the IHS Diabetes Audit that is an annual systematic audit of almost 10,000 charts. Beginning in FY 2001, these indicators will be based on three-year running averages from this audit.

The software used by IHS facilities and most tribal facilities is the Resource and Patient Management System (RPMS). Data are collected for each inpatient discharge, ambulatory medical visit, and dental visit (all patient specific) and for community health service programs including health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse (all activities

reporting systems). The patient-specific data are collected through the Patient Care Component (PCC) of the RPMS. For a discussion of data validation processes relative to this system and the diabetes audit, see Appendix A.1 on page 124.

**Performance Summary Table 1:
Treatment Indicators**

Performance Indicator	FY Targets	Actual Performance	Reference
Diabetes Group			
Indicator 1: Track Area age-specific diabetes prevalence rates (as a surrogate marker for diabetes incidence) for the AI/AN population.	FY 02: maintain data-base FY 01: maintain data-base FY 00: maintain data-base FY 99: establish baseline	FY 02: FY 01: FY 00: data-base maintained** FY 99: baseline established	P: p. 49 B: p. IHS-27 p. IHS-129 ** provisional data pending final verification
Indicator 2: Increase the proportion of I/T/U clients with diagnosed diabetes that have improved their glycemic control.	Ideal Glycemic Control FY 02: 3-year average improved FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 25% Good Glycemic Control FY 99: 38%	FY 02: FY 01: FY 00: 7/01 FY 97-99: 24% FY 99: 25% FY 98: 22% FY 99: 35% FY 98: 35%	P: p. 50 B: p. IHS-27 p. IHS-129 New FY 1999 Data
Indicator 3: Increase the proportion of I/T/U clients with diagnosed diabetes and hypertension that have achieved diabetic blood pressure control standards.	Ideal Hypertension Control FY 02: 3-year average improved FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 41%	FY 02: FY 01: FY 00: 7/01 FY 99: 36% FY 97-99: 37% FY 98: 38% ¹	P: p. 52 B: p. IHS-27 p. IHS-129 New FY 1999 Data ¹ baseline corrected, see page 54
Indicator 4 : Increase the proportion of I/T/U clients with diagnosed diabetes who have been assessed for dyslipidemia.	LDL Cholesterol FY 02: 3-year average improved FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 32% Total Cholesterol FY 99: 82%	FY 02: FY 01: FY 00: 7/01 FY 98-99: 38% FY 99: 46% FY 98: 29% FY 99: 72% FY 98: 79%	P: p. 53 B: p. IHS-27 p. IHS-129 New FY 1999 Data

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 5: Increase the proportion of I/T/U clients with diagnosed diabetes who have been assessed for nephropathy.	FY 02: 3-year average improved FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 36%	FY 02: FY 01: FY 00: 7/01 FY 97-99: 31% FY 99: 36% FY 98: 33%	P: p. 54 B: p. IHS-27 p. IHS-129 New FY 1999 Data
Cancer Screening Group			
Indicator 6: Increase the proportion of women who receive Pap screening.	<u>Pap Screening</u> FY 02: +2% over FY 01 level FY 01: +3% over FY 00 level* FY 00: +3% over FY 99 level FY 99: no indicator <u>Cervical Cancer</u> FY 99: determine incidence of cervical cancer	FY 02: FY 01: FY 00: 11.9% in past year 17.9% in past 3 years from electronic sample baseline FY 99: baseline not adequate see page 58 FY 99: 8-10 per 100,000 based on 40% of AI/AN	P: p. 55 B: p. IHS-27 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 128-132. ** provisional data pending final validation
Indicator 7: Increase proportion of the AI/AN female population over 40 years of age who receive screening mammography.	FY 02: +2% over FY 01 level FY 01: +2% over FY 00 level* FY 00: +3% over FY 99 baseline FY 99: establish baseline	FY 02: FY 01: FY 00: 14.7% over past 2 years** from electronic sample baseline FY 99: baseline not adequate see page 60	P: p. 57 B: p. IHS-27 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 128-132. ** provisional data pending final validation
Well Child Care Indicator			
Indicator 8: Increase the proportion of AI/AN children receiving a minimum of four Well Child Visits by 27 months of age and expand coverage.	FY 02: +2% over FY 01 FY 01: +2% over FY 00* FY 00: +3% over FY 99 FY 99: establish baseline	FY 02: FY 01: FY 00: 47.7**% (+9.2% over FY 99) FY 99: 38.5% baseline	P: p. 59 B: p. IHS-27 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 128-132. ** provisional data pending final validation

Performance Indicator	FY Targets	Actual Performance	Reference
Alcohol and Substance Abuse Group			
Indicator 9: Maintain the rates and intensity of follow-up for adolescents discharged from IHS supported Regional Treatment Centers (RTC) to assure reduced rates of alcohol and drug use.	<u>Abstinence</u> FY 02: +5% over FY 01 FY 01: +5% over FY 00 FY 00: no indicator <u>Follow-up Rates</u> FY 02: FY 01 level or higher FY 01: FY 00 level or higher FY 00: 45% (+10% over FY 99 for 3 follow-ups by 12 months post discharge) FY 99: establish baseline for 12 months, 6 months, and 30 days follow-up rates	FY 02: FY 01: FY 00: FY 00: baseline abstinence 05/01 FY 02: FY 01: FY 00: 48% % -12 mos (+17%) FY 99: 40.9% -12 mos baseline 55.2% -6 mos 64.5% -30 days	P: p. 60 B: p. IHS-51
Indicator 10: Expand the percentage of I/T/U prenatal clinics utilizing screening and case management protocols for pregnant substance abusing women and advocate to expand usage.	FY 02: + 5% over FY 01 FY 01: + 10% over FY 00 FY 00: +5% over FY 99 FY 99: establish baseline	FY 02: FY 01: FY 00: 87.6% (+11.7% over FY 99) FY 99: 78.4%	P: p. 61 B: p. IHS-41 New FY 1999 Data
Oral Health Group			
Indicator 11: Increase access to optimally fluoridated water for the AI/AN population.	FY 02: 10% over FY 01 for AI/AN pop. receiving fluor. water FY 01: 10% over FY 00 for demo Areas 5% over FY 00 for other Areas* FY 00: 15% over FY 99 for demo Areas FY 99: no indicator	FY 02: FY 01: FY 00: 18 systems in compliance (38% increase) FY 99: 13 systems in compliance for demo Areas or 2%	P: p. 63 B: p. IHS-37 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 128-132.
Indicator 12: Increase annual access to dental services for the AI/AN population.	FY 02: +1% over FY 01 FY 01: 27% FY 00: 23% FY 99: 21%	FY 02: FY 01: FY 00: 25.1% FY 99: 25.1% FY 98: 24.5% FY 97: 22%	P: p. 64 B: p. IHS-37

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 13: Increase the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth.	<u>6-8 yrs</u> FY 02: +1% over FY 01 FY 01: +3% over FY 00 FY 00: +3% over FY 99 FY 99: 50% (36.1% recalculated.) <u>14-15 yrs</u> FY 02: +1% over FY 01 FY 01: +3% over FY 00 FY 00: +3% over FY 99 FY 99: 58% (59% recalculated)	FY 02: FY 01: FY 00: 44.1% (+ 4.5%)** FY 99: 39.6% ¹ FY 91: 40.1% corrected baseline FY 02: FY 01: FY 00: 49.1% (-15.9%)** FY 99: 65.0% ¹ FY 91: 66.5% corrected baseline	P: p. 66 B: p. IHS-37 ** provisional data pending final validation ¹ see page 67 for explanation of revised FY 99 rates
Indicator 14: Increase the proportion of the AI/AN population diagnosed with diabetes that obtain access to dental services annually.	FY 02: 2% increase over FY 01 FY 01: no indicator FY 00: no indicator FY 99: no indicator	FY 02: FY 01: 7/01 FY 00: 7/01 FY 99: 30%	P: p. 67 B: p. IHS-37
Indicator 15: Decrease the proportion of the AI/AN children 6-8 and 14-15 years with untreated dental decay.	<u>6-8 yrs</u> FY 02: 2% under FY 01 baseline FY 01: no indicator FY 00: no indicator FY 99: no indicator <u>14-15 yrs</u> FY 02: 2% under FY 01 baseline FY 01: no indicator FY 00: no indicator FY 99: no indicator	FY 02: FY 01: establish electronic baseline FY 00: FY 99: FY 02: FY 01: establish electronic baseline FY 00: FY 99:	P: p. 68 B: p. IHS-37.
Family Abuse, Violence, and Neglect Indicator			
Indicator 16: Increase the % of I/T/U medical facilities with Urgent Care or Emergency departments or services that have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (i.e., child, spouse, elderly) and train staff in their use	<u>Staff Training</u> FY 02: 56% FY 01: no indicator FY 00: no indicator FY 99: no indicator <u>Policies and Procedures</u> FY 02: 82% FY 01: 80% FY 00: 70% FY 99: 60%	<u>Staff Training</u> FY 02: FY 00: 54% (baseline) <u>Policies and Procedures</u> FY 02: FY 01: FY 00: 72% FY 99: 64% FY 98: 47% (baseline)	P: p. 69 B: p. IHS-43

Performance Indicator	FY Targets	Actual Performance	Reference
Information Technology Development Group			
Indicator 17: Expand the automated extraction of GPRA clinical performance measures by developing test sites to assess and improve data quality.	FY 02: assess 5 sites for 5 performance measures FY 01: setup 5 sites for testing 5 performance measures FY 00: no indicator FY 99: no indicator	FY 02: FY 01:	P: p. 72 B: p. IHS-137
Indicator 18: Expand the number of I/T/U programs that have implemented the use of the Mental Health/Social Services (MH/SS) data reporting system.	FY 02: +5 over FY 01 level FY 01: +10 over FY 00 level FY 00: +10 over FY 99 level FY 99: 50%	FY 02: FY 01: FY 00: 51% FY 99: 51% FY 98: est. 40-45% baseline	P: p. 74 B: p. IHS-143
Indicator 19: Develop the specifications and implementation plan for an automated mutually compatible information system, which captures health status, and patient care data for Indian Urban health care programs and implement at field urban sites.	FY 02: +10 over FY 01 level FY 01: implemented in 30% of urban programs FY 00: test in at least one site FY 99: develop specs and plan	FY 02: FY 01: FY 00: tested in several sites FY 99: accomplished 8/99	P: p. 75 B: p. IHS-93
Quality of Care Group			
Indicator 20: Maintain 100% accreditation of all IHS hospitals and outpatient clinics.	FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100%	FY 02: FY 01: FY 00: 100% FY 99: 100% FY 98: 100% (baseline)	P: p. 76 B: p. IHS-27 p. IHF-11
Indicator 21: Improve AI/AN consumer satisfaction with the acceptability and accessibility of health care as measured by IHS consumer satisfaction survey.	FY 02: secure baseline FY 01: secure Federal clearance* FY 00: Federal clearance and establish baseline FY 99: develop instrument and protocol	FY 02: FY 01: FY 00: submitted but clearance not completed FY 99: instrument and protocol complete	P: p. 77 B: p. IHS-27 p. IHS-109 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Total Treatment Funding:	FY 02: \$2,746,954,000* FY 01: \$2,117,008,000 FY 00: \$1,931,326,000 FY 99: \$1,811,951,000 FY 98: \$1,711,018,000 *includes 85% of M/M and PI collections and Diabetes		P: page # in perform. plan B: page # in budget justif.

A. FY 2002 Treatment Indicators:

Diabetes Group:

The following five indicators address the ongoing monitoring and treatment of diabetes in the AI/AN population. Diabetes continues to be a growing problem in many AI/AN communities with rates increasing rapidly in several Areas, age at diagnosis occurring at younger ages, and no signs of decline in any Area. The impact of this disease in terms of individual and family suffering is immense, as are the treatment costs to the Indian health delivery systems. These treatment indicators were selected because of their proven benefits in reducing the morbidity and mortality associated with this condition.

Indicator 1: During FY 2002, continue tracking (i.e., data collection and analyses) Area age-specific diabetes prevalence rates to identify trends in the age-specific prevalence of diabetes (as a surrogate marker for diabetes incidence) for the AI/AN population.

Rationale: This indicator is an essential part of monitoring progress of ongoing efforts in the treatment and prevention of diabetes. Though incidence rates of diabetes (occurrence of new cases within a certain time period) are very difficult and expensive to collect, and are only done reliably in large, population-based studies, trends in age-specific prevalence rates of diabetes can provide evidence of an increase or decrease in diabetes for a certain age group and may suggest a change in true incidence. Analysis of these trends will allow the program and I/T/U's to target prevention efforts to specific age groups and locations in ongoing and future interventions.

Approach: The IHS Office of Public Health is responsible for overall coordination of efforts to achieve this indicator. The IHS Diabetes Program estimates diabetes prevalence of diagnosed diabetes in Native Americans seeking care in I/T/U facilities. Rates are calculated using the IHS automated record system (i.e., PCC/RPMS data), and are reported by geographic Area, gender, and age groups for adults. Three-year rates will be calculated to reduce variability. Three-year running rates (i.e., add the most recent year of data and drop the oldest year of data) will be used in trend analysis. Longitudinal studies of diabetes conducted in Pima Indians since 1965 have provided extensive information on the prevalence and incidence of diabetes in this tribal community. While there are several other tribal-specific diabetes epidemiological studies, none are to the depth of the Pima studies and they cover fewer than 10% of all tribes. Furthermore, there are no published studies on the growing problem of type II diabetes in American Indian youth, though there is extensive recognition by I/T/U providers that the age of diabetes onset is declining to younger adults and children.

Local/tribal facilities can assess diabetes prevalence by using PCC registries and /or diabetes case registries, deriving baseline measures for their tribal communities. The IHS Diabetes Program and the IHS Chronic Disease Epidemiology Program can assist I/T/U facilities to enhance their PCC registries and/or other diabetes registries, as well as establish and organize systematic screening and data entry in order to better ascertain diabetes prevalence. Emphasis will be placed upon the specific age groups identified for this measure.

Diabetes prevalence information will be collected, transformed into similar formats, and transferred to the CDC Division of Diabetes epidemiologist (interagency agreement between CDC and IHS) for analysis and adjusting. Reports will be created and disseminated to I/T/U's, other DHHS agencies, universities, and private foundations for use in identifying prevention strategies and resources.

Data Source: RPMS/PCC reports, Diabetes Registries

Baseline: This indicator commits to establishing and maintaining diabetes prevalence baselines using the IHS PCC and local diabetes registries that are used now in all areas. These rates will serve as the baseline for tribal-specific prevalence studies in selected tribes and will be determined annually.

Type of Indicator: Process and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. It is supported by IHS/CDC agreements, and supports several HP 2010 objectives in Focus Area 5: Diabetes.

Program Performance: The FY 2000 performance measure was to maintain the Area age-specific prevalence rates for diabetes and has been accomplished. Area age-specific diabetes prevalence rates have been prepared for the AI/AN population based on patients diagnosed with and treated for diabetes and having at least one outpatient visit during FY 1998. Rates are available by IHS Area and sex for 4 age groups (0-19, 20-44, 45-64, and 65+). The chart below summarizes the prevalence of diabetes in the AI/AN population.

**Prevalence (%)* of American Indians/Alaska Natives
with Diagnosed Diabetes,
by Age Group and IHS Service Area, 1998**

Area	Age group				ALL
	<20	20-44	45-64	≥65	
Alaska	0.1	1.0	7.2	14.7	2.1
California	0.2	2.2	12.6	18.6	3.9
Portland	0.2	2.5	16.1	19.8	4.1
Oklahoma	0.2	3.7	17.9	19.3	5.7
Navajo	0.1	3.4	23.4	30.3	5.7
Albuquerque	0.1	4.9	28.8	31.7	7.3
Aberdeen	0.2	6.0	31.4	31.5	7.3
Billings	0.3	4.9	30.9	37.8	7.3
Bemidji	0.4	5.3	30.1	36.5	7.9
Phoenix	0.4	7.0	29.8	34.9	8.4
Tucson	0.5	8.0	34.3	31.3	9.4
Nashville	0.4	13.0	44.9	36.8	13.4
ALL	0.2	4.1	21.8	25.2	6.0

Indicator 2 : During FY 2002, continue the trend of improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Rationale: This indicator is directed at reducing diabetic complications. Large clinical studies have demonstrated that glycemic control significantly reduces the incidence of complications related to diabetes. In addition, achieving better blood sugar control has been shown to

significantly reduce the costs associated with caring for people with diabetes. Using Staged Diabetes Management treatment guidelines for diabetes clinical management has significantly improved glucose control in several Indian communities.

Approach: The IHS Diabetes Program conducts an annual medical record review of a random sample of nearly 12,000 charts in I/T/U facilities in order to assess compliance with the IHS Standards of Care for Diabetes. These standards are a set of clinical parameters of care and patient management that have a recognized evidence-based correlation with improved diabetic patient outcomes. This record review is known as the IHS Diabetes Care and Outcomes Audit and uses a strict protocol to assure statistical integrity and comparability of both process and outcome measures over time. Each year, facility-specific values are reported for each indicator, as well as values for each Area and IHS-wide. Trends over time for I/T/U facilities, service units, Areas and IHS-wide are also constructed for selected indicators. Three-year running rates (i.e., add the most recent year of data and drop the oldest year of data) will be used to reduce variability and provide trend analysis.

Glycemic control refers to how well the blood sugars are controlled in a person with diabetes. It is measured with a blood test called the Hemoglobin A1c that measures the average blood sugar for a 2-3 month period. The IHS Diabetes Care and Outcomes Audit process divides these levels of control into "Ideal" (<7%); "Good" (7.0-7.9%); "Fair" (8.0-9.9%); "Poor" (10-11.9%); "Very Poor" (>12%) categories based on national diabetes care standards. These categories will be used in the GPRA process to determine improvements in glycemic control.

The benefits of aggressive interventions to lower blood sugar in diabetics have been well described in the literature and numerous practice guidelines and standards exist. The use of appropriated diabetes funding enhancements will improve the performance of this indicator through the use of grants / cooperative agreements for special projects aimed at targeted diabetes-related treatment and prevention areas. Local efforts to improve these parameters through lifestyle intervention and appropriate medication use will be encouraged through orientation, training, and monitoring provided by Area Diabetic Coordinators. Efforts to achieve this measure also include the negotiation of wholesale/at cost purchase of newer, more effective (but considerably more expensive) medications for AI/AN diabetic patients.

Data Source: Diabetes registries, yearly IHS Diabetes Care and Outcomes Audit

Baseline: The 1997-99 three-year running average of the proportion of all I/T/U clients with diabetes in the desired categories of glycemic control is 24% for "Ideal" control.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements and addresses Year 2010 objective 5-6 (Diabetes: diabetes-related deaths).

Program Performance: FY 2000 data for this indicator will be available 7/01 when analyses of the IHS Diabetes Care and Outcomes Audit are completed. The FY 1999 Indicator was to increase the proportion of I/T/U clients with diagnosed diabetes who have improved their

glycemic control by 3% over the FY 1998 level. The baseline criteria for this indicator was originally set on the "Good" control category, which was unchanged at 35% for FY 1998 and FY 1999 at the define "Good" level. However, the IHS Diabetes Care and Outcomes Audit recently updated its criteria for glycemic control based on the American Diabetes Association guidelines that recommend the use of Hemoglobin A1c (HbA1c) cutoffs to determine control at the "Ideal" level. Based on this new criterion, the IHS is adopting it as the basis for assessing this indicator. In FY 1998 the proportion of our patients with diagnosed diabetes who were classified as "Ideal" was 22% while in FY 1999 that proportion increased to 25% and we have thus met the 3% increase target for this indicator.

Indicator 3: During FY 2002, continue the trend of improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.

Rationale: This indicator is directed at reducing diabetic complications. Large clinical studies have demonstrated that blood pressure control significantly reduces the incidence of complications related to diabetes. In addition, achieving better blood pressure control has been shown to significantly reduce the costs associated with caring for people with diabetes. Using Staged Diabetes Management treatment guidelines for diabetes clinical management has significantly improved blood pressure control in several Indian communities.

Approach: The IHS Diabetes Program conducts a yearly medical record review of a random sample of over 12,000 charts in I/T/U facilities in order to assess compliance with the IHS Standards of Care for Diabetes. These standards are a set of clinical parameters of care and patient management that have a recognized evidence-based correlation with improved diabetic patient outcomes. This record review is known as the IHS Diabetes Care and Outcomes Audit and uses a strict protocol to assure statistical integrity and comparability of both process and outcome measures over time. Each year, facility-specific values are reported for each indicator, as well as values for each Area and IHS-wide. Trends over time for I/T/U facilities, service units, Areas and IHS-wide are also constructed for selected indicators. Three-year running rates (i.e., add the most recent year of data and drop the oldest year of data) will be used to reduce variability and provide trend analysis.

Blood pressure control is usually defined in the non-diabetic person as a blood pressure level less than 140/90 mm Hg. However, because a person with diabetes is at greater risk for complications related to blood pressure, national standards recommend that the ideal goal of diabetic blood pressure control should be 130/85 mm Hg. For the GPRA process, "controlled" level will be defined as 140/90 mm Hg and "ideal" control will be defined as 130/85 mm Hg. and both levels will be reported.

The benefits of aggressive interventions to lower blood pressure in diabetics have been well described in the literature and numerous practice guidelines and standards exist. The use of appropriated diabetes funding enhancements will improve the performance of this indicator through the use of grants / cooperative agreements for special projects aimed at targeted diabetes-related treatment and prevention areas. Local efforts to improve these parameters through lifestyle intervention and appropriate medication use will be encouraged through orientation, training, and monitoring provided by Area Diabetic Coordinators. Efforts to achieve this measure also include the negotiation of wholesale/at cost purchase of newer, more effective (but considerably more expensive) medications for AI/AN diabetic patients.

Data Source: Diabetes registries, yearly IHS Diabetes Care and Outcomes Audit

Baseline: The 1997-99 three-year running average of the proportion of all I/T/U clients in the ideal control (<130/85 mm Hg) category was 37%.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements and addresses Year 2010 objectives 5-6 (Diabetes: diabetes-related deaths) and 5-7 (Diabetes: cardiovascular deaths).

Program Performance: FY 2000 data for this indicator will be available 7/01 when analyses of the IHS Diabetes Care and Outcomes Audit are completed. The FY 1999 Indicator was to increase the proportion of I/T/U clients with diagnosed diabetes who have achieved diabetic blood pressure control by 3% over the FY 1998 level. Since last year we have adopted the "idea" control standard as our benchmark for all future comparisons. This indicator was not met for FY 1999. In the "ideal" control category, the rate actually decreased from 38% in FY 1998 to 35% in FY 1999. In last year's submission the baselines presented were not correct. That error has been corrected this year, and is based solely on the ideal control category. The IHS National Diabetes Program is encouraging programs to use the new diabetes funding to enhance their clinical care programs, including better blood pressure screening and more aggressive treatment as well as increased funds to the pharmacy budget to purchase newer, more effective antihypertensive agents.

Indicator 4: During FY 2002, continue the trend of increasing the proportion of I/T/U clients with diagnosed diabetes assessed for dyslipidemia (i. e., LDL cholesterol).

Rationale: This indicator is directed at reducing diabetic complications. Large clinical studies have demonstrated that lowering of serum cholesterol significantly reduces the cardiovascular (CVD) morbidity and mortality associated with diabetes. In addition, achieving better control of lipid parameters has been shown to significantly reduce the CVD costs associated with caring for people with diabetes. Using Staged Diabetes Management treatment guidelines for lipid management has significantly improved lipid control in patients with diabetes.

Approach: The IHS Diabetes Program conducts a yearly medical record review of a random sample of over 12,000 charts in I/T/U facilities in order to assess compliance with the IHS Standards of Care for Diabetes. These standards are a set of clinical parameters of care and patient management that have a recognized evidence-based correlation with improved diabetic patient outcomes. This record review is known as the IHS Diabetes Care and Outcomes Audit and uses a strict protocol to assure statistical integrity and comparability of both process and outcome measures over time. Each year, facility-specific values are reported for each indicator, as well as values for each Area and IHS-wide. Trends over time for I/T/U facilities, service units, Areas and IHS-wide are also constructed for selected indicators. Three-year running rates (i.e., add the most recent year of data and drop the oldest year of data) will be used to reduce variability and provide trend analysis. However, because this measure was not included in the audit until 1998, for the FY 2000 performance report the baseline will be the 1998-99 two-year

running average. Beginning with the FY 2001 performance report the baseline for comparison will be the previous three-year running average

The benefits of aggressive interventions to lower cholesterol levels in diabetics have been well described in the literature and numerous practice guidelines and standards exist. The use of appropriated diabetes funding enhancements will improve the performance of this indicator through the use of grants / cooperative agreements for special activities aimed at targeted diabetes-related treatment and prevention areas. Local efforts to improve these parameters through lifestyle intervention and appropriate medication use will be encouraged through orientation, training, and monitoring provided by Area Diabetic Coordinators.

Data Source: Diabetes registries, yearly IHS Diabetes Care and Outcomes Audit

Baseline: The 1998-99 two-year running average of the proportion of all I/T/U clients with diabetes who have had a LDL cholesterol assessment done is 38%.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements and addresses Year 2010 objectives 5-6 (Diabetes: diabetes-related deaths) and 5-7 (Diabetes: cardiovascular deaths).

Program Performance: FY 2000 data for this indicator will be available 7/01 when analyses of the IHS Diabetes Care and Outcomes Audit are completed. The FY 1999 Indicator was to increase the proportion of I/T/U clients with diagnosed diabetes assessed for dyslipidemia by 3% over the FY 1998 level. Screening for total cholesterol and triglycerides actually decreased overall from 79% in 1998 to 72% in 1999. However, as new research from cardiovascular disease studies in AI/AN became available through the Strong Heart Study, we have learned it is more cost effective to place our emphasis on the "important" cholesterol (LDL cholesterol). So our emphasis to providers over the past year has been to increase LDL cholesterol screening, and we are pleased to report that screening increased from 29% in 1998 to 46% in 1999. The criterion for screening for dyslipidemia has been changed to the assessment of only LDL cholesterol in AI/AN diabetics.

Indicator 5: During FY 2002, continue the trend of increasing the proportion of I/T/U clients with diagnosed diabetes assessed for nephropathy.

Rationale: This indicator is directed at reducing diabetic complications. End stage renal disease (ESRD), or diabetic kidney disease, is a significant and growing problem in Indian communities. Large clinical studies have demonstrated that certain measurements can identify those patients at high risk for ESRD and that interventions aimed at reducing risk (blood pressure control, and other "state of the science" medications) may delay the onset of ESRD. Using the Kidney Health Profile of the diabetes audit and the Staged Diabetes Management treatment guidelines for diabetes clinical management may significantly improve the approach to kidney health in Indian communities.

Approach: The IHS Diabetes Program conducts a yearly medical record review of a random sample of nearly 10,000 charts in I/T/U facilities in order to assess compliance with the IHS Standards of Care for Diabetes. These standards are a set of clinical parameters of care and patient management that have a recognized evidence-based correlation with improved diabetic patient outcomes. This record review is known as the IHS Diabetes Care and Outcomes Audit and uses a strict protocol to assure statistical integrity and comparability of both process and outcome measures over time. Each year, facility-specific values are reported for each indicator, as well as values for each Area and IHS-wide. A special sub-report of the audit, called the Kidney Health Profile, is generated which assesses screening and treatment for kidney health in a community. Three-year running rates (i.e., add the most recent year of data and drop the oldest year of data) will be used to reduce variability and provide trend analysis.

The benefits of aggressive interventions to lower blood pressure in diabetics relative to kidney health have been well described in the literature and numerous practice guidelines and standards exist. The use of appropriated diabetes funding enhancements will improve the performance of this indicator through the use of grants / cooperative agreements for special activities aimed at targeted diabetes-related treatment and prevention areas. Local efforts to improve these parameters through lifestyle intervention and appropriate medication use will be encouraged through orientation, training, and monitoring provided by Area Diabetic Coordinators.

Data Source: Diabetes registries, yearly IHS Diabetes Care and Outcomes Audit

Baseline: The 1997-99 three-year running average of the proportion of all I/T/U clients with diabetes screened for "kidney health" (based on microalbuminuria) is 31%.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It is supported by IHS/CDC agreements and addresses Year 2010 objective 5-11 (Diabetes: proteinuria).

Program Performance: FY 2000 data for this indicator will be available 7/01 when analyses of the IHS Diabetes Care and Outcomes Audit are completed. The FY 1999 Indicator was to increase the proportion of I/T/U clients with diagnosed diabetes assessed for nephropathy by 3% over the FY 1998 level and was achieved. Screening for microalbuminuria to assess early diabetic nephropathy increased from 33% in 1998 to 36% in 1999.

Cancer Screening Group:

These two indicators are directed at increasing the coverage of women receiving screening for breast and cervical cancer and thus increase cancer survival rates and reduce cancer mortality.

Indicator 6: During FY 2002, increase the proportion of women 18 and older that has had a Pap screen in the previous year by 2% over the FY 2001 level.

Rationale: The purpose of this indicator is to reduce cervical cancer morbidity and mortality by early detection. This indicator is selected because cervical cancer occurs at higher rates among AI/AN women than in the general U. S. population. The death rate for AI/AN women is 4.1 per

100,000 compared with 2.5 per 100,000 for the U.S. All Races rate. Furthermore, this cancer is the cause of significant premature mortality, and is almost entirely preventable by thorough Pap screening and early treatment of pre-cancerous conditions. The long-range goal is to reduce both cervical cancer incidence and death rates to achieve parity with the U. S. all-races rate. This may be attainable within 10 years. This indicator supports a nationally recognized standard of care.

Approach: The IHS Office of Public Health is responsible for overall coordination of efforts to achieve these indicators. Public education, training providers to perform colposcopy and treatment, and aggressive follow-up of abnormal Paps will all be part of the strategy. IHS clinical coordinators will work closely with CDC-funded Breast and Cervical Cancer screening programs in States and Tribal Health Departments to ensure that papscreening services are available to all AI/AN women.

Data Source: We had proposed to establish a baseline Pap coverage rate by April, 2000 using information from the electronic medical records (National Patient Information Resource System, NPIRS) from the IHS data center. We did not succeed in establishing this baseline because of technical problems with transferring to a new computer platform and diversion of key personnel to Y2K efforts. However, at the end of 2000 we were able for the first time to determine the pap coverage rate for all women by using these electronic records. A random sample of 5000 AI/AN women over 18 (N=460,377) was selected from the central NPIRS file, and records scanned for either laboratory or clinic visit information indicating that a pap was performed during the previous 12 and 36 months. The percentage of women in the sample who had a pap in the previous 12 months is reported as the pap coverage rate. Current recommendations call for a pap every three years for most women, so the 36month rate is reported as well. Because of concerns about the completeness of data in this central system, this will be followed by a manual chart review of a subset of patients in the sample. After this validation study has been completed (spring 2001), we will be able to make a determination about the adequacy of this method for GPRA indicator measurement, and will plan data improvement efforts to improve the accuracy of this measurement technique.

Baseline: The report from FY 2000 will serve as the baseline for subsequent years.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 Increase the Availability of Primary Health Services, 3.6 Improve the Health Status of American Indians and Alaska Natives, 4.1 Promote the Appropriate Use of Effective Health Care, and 4.2 Reduce Disparities in the Receipt of Quality Health Care Services. It is supported by IHS/CDC agreements (National Breast and Cervical Cancer Early Detection Program). This indicator also, directly supports the HP 2010 objective 3-4 (Cancer: cervical cancer deaths).

Program Performance: The FY 2000 performance indicator was to increase the proportion of women who have annual Pap screening by 3% over the FY 1999 baseline. As discussed above, a reliable baseline for comparison was not possible with our available systems during FY 1999. However, we have established a new electronic sample derived baseline for FY 2000:

- 11.9% of AI/AN women over age 18 had a Pap test within one year;
- 17.9% had a Pap test within three years.

Current recommendations for cervical cancer prevention call for a Pap for all women at least once every three years beginning at age 18 or onset of sexual activity. High risk women should

have a Pap annually. If the 3-year recommendation were universally applied, we should expect to see around 30% of women having a pap every year, and nearly 100% every 3 years. Our observed numbers of 11.9% and 17.9% are far short of that goal. More detailed studies have shown that younger AI/AN women get Pap screening at high rates, but then stop getting screened when they are past child-bearing age. To address this problem, IHS is collaborating with CDC to increase the numbers of older AI/AN women who are screened through the National Breast and Cervical Cancer Early Detection Program.

Indicator 7: During FY 2002, increase the proportion of the AI/AN female population over 40 years of age that has received screening mammography in the previous two years by 2% over the FY 2001 level.

Rationale: The purpose of this indicator is to reduce breast cancer morbidity and mortality by early detection. Breast cancer has long been considered to be rare among AI/AN women. Incidence and mortality rates have been documented in some AI/AN populations to be 1/3 to 1/2 of the White rates. Because of historically low rates of breast cancer among AI/AN women, and because of competing priorities, screening mammography was not a high priority for IHS in the past. This picture seems to be changing, however, with breast cancer incidence in the northern plains and Alaska now approaching the rates of the White population. IHS seldom performed screening mammography before 1991, when the CDC National Breast and Cervical Cancer Early Detection Program was initiated. The CDC funded programs have been successful in reaching AI/AN women in many states, and not so successful in others.

Mammography every one or two years is a nationally recognized standard of care based on its association with both reduced mortality and morbidity because breast cancer is identified at earlier stages. Early identification allows for early clinical intervention and secondary prevention of morbidity and mortality.

Approach: Local service sites that have mammography units are responsible for delivering the screening. There were only six such IHS service sites in 2000. All other sites must refer women to mammography facilities through either the Contract Health Service process or through CDC-funded State or Tribal screening programs. Regional coordination and assistance is the responsibility of the IHS Area offices. The IHS Office of Public Health performs the overall coordination of this effort. Linkages with CDC, State Health Departments, and the American College of OB/GYN are critical to success.

The strategic approach includes outreach to improve patient access and the availability of specialized staff and equipment to perform the screenings. The staff required include public health nurses, Community Health Representatives, and health educators to improve outreach, and specialized clinical providers (nursing, physician, and imaging staff) to provide the actual clinical breast exams and mammograms. The availability of screening must also be associated with the capability to provide diagnostic studies such as ultrasound, biopsy, and fine needle aspiration, as well as treatment such as surgery and chemotherapy.

The successful reduction of premature deaths and morbidity among AI/AN women will depend on full implementation of effective screening and follow-up clinical services. This indicator is linked to success in meeting Strategic Objectives one, two, and four of the Agency's component of the DHHS Strategic Plan.

Data Source: In FY 1999 we intended established a baseline mammography coverage rate using information from the Diabetes Audit, a survey of care among people with diabetes. However, mammography was dropped from the diabetes audit beginning in FY 1999 and we were thus had to develop an alternative approach.

In FY 2000 for the first time we attempted to determine the mammography coverage rate for all women by using electronic medical records (National Patient Information Resource System, NPIRS) from the IHS data center. A random sample of 5000 AI/AN women over 40 was selected from this central file, and records scanned for either radiology, clinic visit, or contract health referral information indicating that a mammogram was performed during the previous 24 months. The percentage of women in the sample who had a mammogram in the previous 24 months is reported as the mammography coverage rate. Because of concerns about the completeness of data in this central system, this will be followed by a manual chart review a subset of patients in the sample. After this validation study has been completed (spring 2001), we will be able to make a determination about the adequacy of this method for GPRA indicator measurement, and will plan data improvement efforts to improve the accuracy of this measurement technique.

Baseline: Our previous baseline was from the Annual Diabetes Audit from 1997, which found that 27% of women with diabetes had been screened for breast cancer in accordance with American Cancer Society guidelines. In addition, we were not satisfied with this baseline because of questions about the representativeness of the sample (diabetic women only) and the expense of the manual chart review. The revised automated approach for FY 2000 uses inexpensive and reproducible methods, and will serve as the baseline for subsequent years.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 Increase the Availability of Primary Health Services, 3.6 Improve the Health Status of American Indians and Alaska Natives, 4.1 Promote the Appropriate Use of Effective Health Care, and 4.2 Reduce Disparities in the Receipt of Quality Health Care Services. It is supported by IHS/CDC agreements (National Breast and Cervical Cancer Early Detection Program). This indicator directly supports HP 2010 objective 3-3 (Cancer: breast cancer deaths).

Program Performance: The FY 2000 performance indicator was to increase the proportion of the AI/AN female population over 40 years old who have had screening mammography during the previous year by 3% over the FY 1999 baseline. This comparison was not possible because mammography was dropped from the diabetes audit and alternative approaches were not developed until FY 2000. Using the new measurement methodology discussed above, in FY 2000 14.7% of AI/AN women over age 40 had a mammogram during the previous two years. This data was derived from the IHS NPIRS central database, as a simple random sample of 5000 women drawn from all AI/AN women over age 40 who had at least one IHS visit during FY 2000 (N=207,398).

We used the two-year interval to have data that were comparable with National reports, and to be consistent with current recommendations and clinical guidelines. The mammography rate is lower than our target rate; we suspect that it represents a significant undercount.

This mammography rate only includes mammograms that are entered into the IHS electronic medical record, which includes primarily those performed by or paid for by IHS. It is highly likely that many AI/AN women get mammograms outside the IHS system, either through State Breast and Cervical Cancer Early Detection Programs (CDC-funded), at health fairs, or from private providers that are paid by private insurance or Medicare/Medicaid. In general, these sources do not contribute records to the IHS record system, so they were not counted in this survey. We are exploring ways to include data from the CDC program and from HCFA in this process, in order to obtain a more accurate count.

Well Child Care Indicator:

Indicator 8: During FY 2002, increase the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age by 2% over the FY 2001 level.

Rationale: This indicator is directed at improving child and family health by expanding access to non-urgent care. Well child visits have been associated with improved post-neonatal mortality and opportunities to improve family health and safety in the longer term and is a recognized national standard of care. Of particular importance are the anticipatory educational interventions given to parents concerning diet and nutrition, injury prevention, and prevention of family violence. The current minimum standard for Well Child Visits is six for first-born children and five after first born. Accepting four visits as an acceptable minimum is based on the high percentage of children who receive Well Child services in conjunction with urgent care visits and thus are not coded as Well Child Visits.

Approach: The responsible parties are the local I/T/U service sites. The IHS Area offices can provide assistance in development and coordination of media campaigns and analysis of information and they are responsible for regional coordination of this effort. The IHS Office of Public Health is responsible for overall coordination of the effort. Linkages with the USDA-WIC program and the DHHS Head Start program are also critical.

The strategies for success are rooted in effective outreach and management of clinic scheduling for service provision. The outreach activity is dependent upon parent education to assure their awareness of the importance of routine and periodic assessment of well children. Secondly, the effective identification of children in the targeted age groups is important. Public health nursing, Community Health Representatives, Head Start programs, and parent groups have important roles in identifying children and families who are the target of this intervention.

Clinical care is dependent upon the availability of trained nursing and physician staff with the time to address this objective. Scheduling and follow up of these children and their families is critical. The cooperation of medical records staff and others in the clinical environment is essential. Achievement of effective well-child health care is critical to the prevention of childhood obesity, injuries, and family dysfunction.

Data Source: RPMS/PCC

Baseline: Determined by the FY 1999 Indicator and reported below

Type of Indicator: Process and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, and 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and broadly addresses the HP 2010 objectives addressing Focus Area 16: Maternal, Infant, and Child Health.

Program Performance: The FY 2000 performance indicator committed to increase by 5% the proportion of AIAN children served by IHS receiving a minimum of four Well Child Visits by 27 months of age, over the FY 1999 baseline. The well child visit indicator was exceeded. In FY 2000, 5,840 children or 47.7% out of 12,237 children received a minimum of four well-child visits by 27 months of age. This is an increase of 9.2% over the FY 1999 proportion of 38.5% (3,799 of 9,873 children). These findings should be considered provisional and may be revised pending the verification and approval of FY 1998-FY 2000 workload by the Areas. Also, modifications to refine the algorithm may be incorporated in the next GPRA cycle.

Substance Abuse Treatment Group:

These two indicators address substance abuse treatment. The first in terms of reducing relapse rates by improved aftercare for youths completing residential treatment programs. The second addresses identification and referral of pregnant woman at risk for alcohol related birth defects.

Indicator 9: During FY 2002, youths discharged from Regional Treatment Centers (RTC) will:

- a. receive follow-up equal to or greater than the FY 2001 level
- b. increase by at least 5% over FY 2001, the youths who have documented 6 months of less alcohol and drug use than before treatment

Rationale: This indicator is intended to reduce drug and alcohol use relapse in youths discharged from the 11 RTCs serving 11 of the 12 IHS Areas. Studies indicate that the longer individuals are engaged in treatment (including aftercare/continuing care) the better the prognosis (Hoffmann, DeHart, & Gogineni, 1998; Zywiak, Hoffmann, & Floyd, 1999). One RTC evaluation concluded, "aftercare is the biggest problem" with limited coordination among RTC, service units and local aftercare programs. This measure aims to assure the effective and efficient delivery of follow-up treatment services at the local level following RTC release. A follow-up consists of a structured case management activity whereby continuity of care, treatment modalities and treatment services are assessed. This assessment of integrated aftercare activities is designed so that an individual's changing needs will be met as that individual moves through the recovery process thereby decreasing relapse.

Approach: The Division of Clinical and Preventive Services, Office of Public Health will be responsible for coordinating data collection from the RTCs who are the responsible parties. The Alcoholism and Substance Abuse Program has developed an ongoing evaluation instrument in consultation with the RTC. The evaluation process began implementation in FY 1998 and includes follow-up information that will be reported to program staff and compiled for tracking this indicator. In addition, those RTC utilizing the RPMS Chemical Dependency Management Information System (CDMIS) and the RPMS Mental Health/Social Service (MH/SS) packages, routinely collect follow up information that can be exported for national reporting purposes. Aftercare services (for those utilizing CDMIS) occurring at local sites will also provide

additional data to support tracking of this indicator as appropriate. Efforts to improve reporting by local tribally managed programs will continue to be solicited.

Findings from the Comprehensive Assessment & Treatment Outcome Research adolescent study indicate that youth engaged in aftercare/follow up activities had better sobriety rates than those who did not, but for optimal benefit, contact frequency of at least twice per week was required (Hoffmann, Mee-Lee, & Arrowood, 1993). The majority of aftercare services are the responsibility of local programs as youth who have completed YRTC treatment return to their community for aftercare services. Although one-year follow-up information was limited in the IHS RTC Evaluation completed in FY 1997, data did suggest that youth that completed treatment and were involved in continuing care and follow-up services maintained higher sobriety rates.

Data Source: Data for this indicator are collected from the RPMS, the RTC evaluation system, and other software utilized by the RTCs and provided to the Areas and Headquarters. Both Area and Headquarters behavioral health staff review the data for completeness and have frequent dialogue with each other or directly with the RTCs to resolve identified data problems. These different sources of data are then analyzed and compiled into one report at Headquarters. Efforts to standardize the RTC data collection format for all RTCs and Areas is a priority during FY 2001 and FY 2002 and will simplify and improve the verification and validation process.

Baseline: The initial baseline for follow-up was established in FY 1999. A baseline assessment for abstinence rates following discharge will be collected during FY 2000 for comparison in FY 2001.

Type of Indicator: Process/Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 1.4 *Curb Alcohol Abuse*, 1.5 *Reduce the Illicit Use of Drugs*, 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also directly supports HP 2010 objective 26-10 (Substance Abuse: reduce youth use of illicit substances).

Program Performance: The FY 2000 performance measure was to increase by 10% the youths discharged from adolescent RTCs who have received at least three follow-up visits in the first year following treatment over the FY 1999 baseline. This target was accomplished in FY 2000 with 48.0% of the youths discharged from RTC who receiving follow-up contacts at 30 days, and at least a second follow-up by 6 months, and at least a third at 12 months after discharge compared to 40.9% in FY 1999 which represents a 17% increase in follow-up. In addition, the percentage of youths who received follow-up in the critical first 30 days following discharged also increased from 64.5% in FY 1999 to 69.5% in FY 2000 for an increase of 7.8%.

Indicator 10: During FY 2002, increase the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 5% over the FY 2001 level.

Rationale: The purpose of this indicator is to contribute to systematic efforts at reducing the incidence of Fetal Alcohol Syndrome (FAS). Surveillance conducted at 2 IHS Areas indicated FAS rates greatly exceed general population rates (2.3 and 2.7/1000 live births vs. 0.6/1000 live

births approximately). The Institute of Medicine 1996 report on FAS includes case identification and appropriate intervention and treatment of a maternal alcohol abuse as a critical part of FAS prevention. Thus, the purpose of this indicator is to assure that providers consistently screen and make appropriate referrals for women at risk. The written protocol makes this more likely because these efforts become part of the local quality assurance process. However, successful implementation of such a process requires staff training as well as cooperation from tribes and local governing bodies and thus requires resources and time.

Approach: The I/T/Us will be responsible for reporting via survey to be conducted by the Division of Clinical and Prevention Services, Office of Public Health relative to the implementation of protocols. Resources for analysis may be required from other divisions within the Office of Public Health. The Prenatal Health Assessment (PHA) screening instrument was developed in the Aberdeen IHS Area with the Centers for Disease Control and Prevention. A curriculum for utilizing the instrument in prenatal clinics and developing case management systems has been piloted in that Area in FY 1998. In the Aberdeen Area, there are numerous clinics and hospitals that are currently using the protocols. In FY 1999 the protocols will be piloted in two new Areas. This screening instrument is one of several recognized protocols that are being encouraged for use in I/T/U programs to assure the routine prenatal substance abuse screening and case management tailored to the resources of each site. The PHA is currently being reviewed by the Medical Records and will be provided for use nationally by the IHS end of FY 1999. A baseline will be established via the survey in 1999 and repeated in 2000.

Data Source: Survey and possibly RPMS

Baseline: Determined by FY 1999 Performance Indicator = 79.6%

Type of Indicator: Process and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 1.4 *Curb Alcohol Abuse*, 1.5 *Reduce the Illicit Use of Drugs*, 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also directly supports several HP 2010 objective 16-16 (Maternal, Infant, and Child Health: Fetal Alcohol Syndrome).

Program Performance: The FY 2000 indicator committed to increasing the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 5% over the FY 1999 level which was 78.4% based on 11 Areas reporting. For FY 2000, all 12 Areas reported for a total of 227 prenatal clinics, 199 had implemented such protocols for a rate of 87.6% that is an 11.7% improvement over FY 1999. Also, in this year all areas reported on this indicator and one area actually went from 70% to 100%, but one area showed no improvement from the FY 1999 baseline.

Oral Health Group:

Because oral diseases seldom result in death or severe disability, the importance of treating and preventing them is often overshadowed by other health priorities, particularly in times of a growing demand for a diversity of urgent care medical services. However, as was made evident from the IHS Dental Program's participation in the 1989-91 World Health Organization oral health status study, the oral conditions of Indian participants were far worse than the U.S.

General population and profoundly influenced their quality of life, including their ability to attend school, work, sleep, eat, and socialize. An overview of the findings of this study was provided in the section titled: "The Role of Poverty, " on page 30 of this document.

Given these poor oral health conditions, it is not surprising that dental health has been consistently identified as a high priority in surveys of American Indian and Alaska Native (AI/AN) consumers' health needs. Furthermore, dental care has been consistently identified in recent stakeholder developed budget formulation activities as one of the top five health priorities for the IHS to address with budget requests.

Indicator 11: During FY 2002, increase the proportion of AI/AN population receiving optimally fluoridated water by 10% over the FY 2001 levels for all IHS Areas.

Rationale: Fluoridation is one of the most cost effective public health measures for reducing the prevalence of dental decay in all age groups. Costs range from a mean of 31 cents per person per year to \$2.12 per person in communities with less than 10,000 people. For many Indian communities, the cost may be up to \$5 per person per year since most of the water systems in Indian country serve less than 1,000 people. It has been estimated that for every dollar spent on fluoridation, there is a \$50 savings in dental treatment. Fluoridation of community drinking water is a major factor responsible for the decline in dental caries (tooth decay) during the second half of the 20th century. In a 1991 oral health survey conducted by the Indian Health Service, there was a 31% decline in caries rates in adolescent children in those communities with access to fluoridated water. However, despite the known benefits of fluoridation, the number of fluoridated water systems in Indian country has declined by 68% over the last nine years. In 1991, 717 water systems were fluoridated and routinely monitored for fluoride ion levels. By 1999, only 226 systems were fluoridated and monitored. This decline in systems has had an adverse impact in the percent of the population that needs the benefits most and are now receiving the least benefits from this proven public health measure.

Approach: The IHS Dental Program, Office of Environmental Health and Engineering Branch, and the Centers for Disease Control and Prevention's Division of Oral Health entered into an interagency agreement in FY 2000 to support a demonstration fluoridation project in the Albuquerque and Phoenix Areas. The funds were used to hire a contractor in each Area to provide on-site visits to each tribe to promote community water fluoridation. The contractor provided information to the community on water fluoridation, assessed need for training and technical assistance for the water operator, and managed the split sample and surveillance system. The contractors will receive training using the CDC's web-based Water Fluoridation Reporting System (WFRS).

The expansion of this indicator to address all IHS Areas in FY 2001 and FY 2002 is the result of earmarked funding of \$500,000 in FY 2001 to support water fluoridation IHS-wide. Rapid export of lessons learned during the demonstration project will be necessary to impact the FY 2001 levels for all other Areas. Areas will expand upon and revise the strategies adopted by the pilot sites in initiating their programs. Each Area will have one individual responsible for fluoridation surveillance and reporting. Funds to each Area may be used to hire a "circuit rider," as was planned at the pilot sites, or in other ways to enhance fluoridation efforts. Each Area will submit an annual plan of action and an annual report of activities and outcomes. For FY 2002, the measure of the indicator will address increasing the proportion of the AI/AN population

receiving optimally fluoridated water from the previous focus of increasing the number of water systems in compliance with fluoridation standards. The compliance standards will remain the same but measuring population encourages efforts be directed where the largest possible population benefit can be achieved from the available resources.

Date Source: Water Fluoridation Reporting System (WFRS) and database maintained by CDC.

Baseline: FY 2001 level available January 2002

Type of Indicator: Impact

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, 4.1 *Promote the Appropriate Use of Effective Health Care*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It also addresses HP 2010 objective 21-9 (Oral Health: community water fluoridation).

Program Performance: The FY 2000 indicator committed to improve water fluoridation compliance by 15% over FY 1999 levels for Areas participating in IHS / CDC Fluoridation Surveillance Demonstration Project (Albuquerque and Phoenix Areas). In FY 1999 only 13 water systems in these Areas met the standard of being in compliance. For FY 2000 this increased to 18 systems or a 38% increase in systems.

Indicator 12: During FY 2002, increase the proportion of the AI/AN population who obtain access to dental services by 1% over the FY 2001 level.

Rationale: This indicator is directed at improving the oral health status. Evidence from large-scale dental insurance studies support that people who utilize dental services annually have improved oral health status compared to those who do not. The growing AI/AN population has resulted in higher demands for dental care and increasing difficulties in recruiting dentists has compounded this problem. As a result, there has been almost a 10% reduction in the percent of the AI/AN population annually receiving dental services in recent years. Restoring access to both primary and secondary treatment and preventive services can lessen the disease progression. Improving access and thus increasing utilization of dental services can also result in less costly care, improved oral health status, and quality of life.

The IHS conducted a program-wide oral health survey in FY 1999 to determine oral health status of the AI/AN population. Preliminary analysis of national oral health survey data suggest:

- moderate increases in tobacco use from 1991 to 1999 in young adults ages 35 – 44; severe increases in tobacco use in adolescents ages 15 – 19. Widespread vacancies preclude the possibility of consistent counseling within the dental program.
- significant increases in the number of decayed, missing, and filled teeth in all age groups from 1991 to 1999. Increases in measured disease experience are inversely correlated with access to dental care.
- significant decreases from 1991 to 1999 in both the number of people served by fluoridated water systems, and the number of young children receiving preventive dental sealants. It is reasonable to assume both unfortunate decreases are exacerbated by the widespread vacancies among oral health care providers.

- In 1991, 717 water systems serving Native Americans were fluoridated and were routinely monitored for fluoride ion levels. By 1999, only 226 systems were fluoridated and monitored.
- In 1999, 78% of adolescents ages 15 – 19 had received one or more dental sealants. This figure, a legacy of the clinical efforts of approximately a decade ago, remains significantly higher than levels of coverage suggested by any national health objective for the U.S. population. In 1999, only 39% of youngsters ages 6 – 8 had one or more sealants.

Approach: Providing access to care is directly dependent upon the dental care resources in a community which include the availability of dental providers and facilities, and their efficiency in providing services. The dental funding enhancements of FY 2001 will be continued in FY 2002 to increase access to dental services through a combination of strategies that include:

- increase the I/T/U dental workforce by increased effectiveness in the recruitment of staff to fill vacant and newly funded dental positions using advance communications technologies, greater use of alternative pay systems, and expanded loan repayment opportunities.
- increase retention and productivity of dental providers through the expansion/enhancement of support centers to provide training and technical assistance to enhance efficiency and effectiveness of preventive and clinical care, and restoration of short and long-term staff training opportunities.
- update and simplify the automated dental record keep system to enhance clinical efficiency and planning and evaluation capability.
- expand essential dental specialty services through contracts with the private sector.
- target specific populations, (i.e., school-age children, diabetics or other special target groups), utilizing third party payers, and identifying Medicaid-eligible families which would result in increased resources to hire additional staff.

For the numerator of this calculation, the dental program will count the number of patients who access I/T/U and contract systems through the dental exam and first visit procedure codes within the Dental component of the PMS patient data record as a valid proxy measure of annual dental care utilization. The denominator will be the IHS three-year user population.

Data Source: IHS Dental Data System component of the RPMS. The IHS Dental Data coordinator compiles dental data monthly from the IHS data processing center and sends to the Area Dental Consultants for verification. Missing data or data that does not look reasonable are addressed by checking back with local programs.

Baseline: FY 2001 level available January 2002

Type of Indicator: Process and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also relates to the HP 2010 objectives 13.12 (Oral Health: referral and follow-up: children) and 21-10 (Oral Health: use of oral health care system).

Program Performance: The FY 2000 indicator committed to achieving the target level of 23% of the AI/AN population receiving dental services. This performance measure was achieved with 25.1% of the user population having accessed dental care during FY 2000. This was derived from 361,823 first appointments recorded in all 12 Areas during FY 2000 divided by the IHS calculated user population 1,452,839 minus 10,585 which is the estimated population of one tribal program that did not submit dental data. Thus, the rate is calculated on 99% of the user population.

The vacancy rate for dental providers of approximately 18% is the key determinant limiting access to care. A full time dental recruiter has been hired; many new strategies to decrease vacancy rate are in the process of being implemented. These include recruitment visits to every U.S. dental school, a professionally designed and produced recruitment package, increased remuneration for incoming dentists, increased opportunities for loan repayment, and other strategies.

Indicator 13: During FY 2002, increase the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth by 1% over the FY 2001 level.

Rationale: The intent of this indicator is to reduce dental decay in children. Dental sealants, a recognized standard of dental care, are an effective measure for reducing dental decay rates in children and can be effectively applied by dental auxiliaries at relatively low cost. Sealants and fluorides can prevent almost all tooth decay and play a role similar to vaccinations. Because surveys of AI/AN children's oral health status have consistently identified significantly higher decay rates than the U. S. general population, sealants are essential to reducing the ravages and costs of treating dental decay. The IHS Dental Program was one of the few dental programs in the nation to have achieved the HP 1990 and 2000 dental sealant objectives. However, based on FY 1999 IHS Oral Health Survey, no significant progress has been achieved since the FY 1991 IHS Oral Health Survey and coverage actually declined for the younger age group. In 1999, 78% of adolescents ages 15 – 19 had received one or more dental sealants. In 1999, only 38% of youngsters ages 6 – 8 had one or more sealants. Again, increasing difficulties in the recruitment and retention of dentists, and the loss of infrastructure, particularly the Area Health Promotion / Disease Prevention officers have probably contributed to the decline in the number of sealants placed in the younger age group.

Given the current workforce in the Indian Health Service dental program, innovative changes in use of auxiliary as well as delivery sites need to occur.

Approach: Local dental clinics are responsible for implementing/maintaining effective and efficient sealant programs that are either school-based or school-linked and targeted for children ages 6-14 years (to coincide with the eruption of first and second permanent molar teeth). Use of a specialized procedure code, which was created specifically to measure use of sealants in school-age children, will enable local programs to track progress in meeting this objective. The Dental Data Software package in the RPMS environment can capture the number of children examined and the number of children who receive dental sealants on a quarterly and annual basis and thus document trends.

In order to increase the percent of Indian children and adolescents that have molar sealants, an innovative approach will be required. The use of contract 4-handed dental sealant teams will be

hired from the private sector. In addition, dental Community Health Aides may be trained to assist dental hygienists and dental assistants in placing sealants. Additional portable equipment to be used in the schools is an efficient way to reduce demands on limited clinic space and going to where the children are – the schools.

Data Source: IHS Dental Data System component of the RPMS.

Baseline: FY 2001 level available January 2002

Type of Indicator: Impact and Balance Scorecard: innovation and learning perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. The indicator also addresses the HP 2010 objective 21-8 (Oral health: dental sealants).

Program Performance: The FY 2000 performance measure was to assure that the percentage of children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth is increased by 3% over the FY 1999 IHS Oral Health Survey level. For FY 2000, only one of the two performance targets was achieved. In FY1999 39.6%* of the children of the 1,513 children ages 6 - 8 in the oral health survey had sealants on their molar teeth. In FY 2000, 44.1% of 7,609 children 6 - 8 years from 5 Areas had sealants on their molar teeth, an increase of 4.5% over FY 1999. However, in FY 1999 65.0%* of 873 children ages 14-15 years in the oral health survey had sealants on their molar teeth, while in FY 2000 only 49.1% of the children in this age group had sealants on their molar teeth, a decrease of 15.9%.

The findings for both age groups must be taken with caution for FY 2000 because they are based on samples from only 5 of the 12 Areas and represent less precise estimates of sealant coverage than the IHS national oral health surveys, which are conducted only once every 7-9 years. Prevalence of children with sealants remains difficult to assess short of running national oral health surveys annually, which is prohibitively expensive. The current method used to derive FY 2000 estimates relies upon the use of codes that are inconsistently utilized. IHS epidemiologists and statisticians are now working to improve the methods for assessing the prevalence of children with sealants in the intervening years between oral health surveys. This approach must be made using replicable and efficient methods undistruptive of the provision of clinical care.

***Note** that these findings have changed slightly from preliminary data reported last year prior to having all outstanding data included in the analyses and now verified for the oral health survey.

Indicator 14: During FY 2002, increase the proportion of the AI/AN population diagnosed with diabetes who obtain access to dental services by 2% over the FY 2001 level.

Rationale: The purpose of this indicator is to improve both oral health status and diabetic control for AI/AN diabetics. Evidence from large-scale dental insurance studies support that people who utilize dental services annually have improved oral health status compared to those who do not. Furthermore, evidence from a study conducted in an IHS setting supported by NIH in collaboration with the State University of New York at Buffalo has shown that that diabetic patients experience periodontal disease more frequently and with greater severity than non-

diabetics. In addition, this study has shown that reduction/elimination of periodontal disease through clinical treatment results in improved glucose control. Additionally, a growing body of evidence has identified periodontal disease as a significant risk factor for heart attack and stroke.

There has been almost a 10% reduction in the percent of the AI/AN population annually receiving dental services in recent years. This reduction in services has also been manifested in a reduction of services for diabetic patients. Restoring access to both primary and secondary treatment and preventive services for diabetics can lessen periodontal disease progression and the subsequent affects on diabetes and overall health. Improving access and thus increasing utilization of dental services can also result in less costly care, improved health status, and quality of life.

Approach: Individual I/T/U hospitals and clinics provide access to care for diabetic patients in a wide variety of ways. Additionally, the level of dental care that is provided to diabetics varies greatly. An emphasis by dental clinics to provide prioritized access to care for diagnosed diabetics would go a long way to improve the oral health of this population. At a minimum, a yearly examination provides an educational opportunity to enlighten the diabetic on their oral health status and proper home care to reduce periodontal disease and it's affect on diabetic control. Those programs with additional time and resources can provide anything from extraction of teeth that are severely involved with periodontal disease to comprehensive periodontal therapy and dentures.

Data Source: Diabetes registries, yearly IHS Diabetes Care and Outcomes Audit

Baseline: FY 2001 actual performance level will serve as baseline and will be available July 2001. For the purpose of showing trend data the FY 1999 performance level was 30% and the FY 2000 level will be available 7/01.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services.*, This indicator also relates to the HP 2010 objective 21-10 (Oral Health: use of oral health care system).

Program Performance: No FY 2000 Indicator

Indicator 15: During FY 2002, reduce the rate of untreated dental decay in children 6-8 year and 14-15 year by 2% below the FY 2001 electronically developed baseline.

Rationale: The purpose of this indicator is to maintain oral health and quality of life for AI/AN children. Evidence supports that untreated dental decay results in higher probability of tooth loss and loss of oral functioning. The 1991 IHS Oral Health Survey documented that 72% of AI/AN 6-8 year olds and 61% of 14 to 15 year olds had untreated decay. Even with the implementation of sealant and fluoride programs for school age children, the 1999-2000 IHS Oral Health Survey identified 62% of 6-8 year olds and 67% of 14-15 year olds with untreated decay. Children with untreated decay can suffer from pain, poor aesthetics, and loss of productive school time. Treating the carious lesions that exist in Native American children will improve their oral health,

their chewing function, their willingness to smile, and will allow them to go about their daily activities without the burden of pain from toothaches. Reduction of untreated dental decay in children will ultimately improve their overall quality of life.

Approach: The principal way to address untreated dental decay is through improved access to dental clinical services. Primary oral health prevention activities will also result in a reduction in untreated decay over time. Additional dental staff, facilities, equipment, and resources to provide preventive and clinical restorative care will be directed to properly deal with this health disparity in the AI/AN population. A list of available interventions include:

- prioritized clinical access for school-aged children
- school-based screening programs to identify children with active decay.
- school-based dental sealant programs.
- school-based fluoride varnish, fluoride rinse, and fluoride gel programs.
- expanded community water fluoridation activities.
- expanded use of new technologies in dental materials including decay control varnishes and glass ionomer restorations.

Data Source: Dental Data System/RPMS data system . On an annual basis, number of code #IH72 divided by the number of dental patients in each age group will yield the percentage of those with untreated decay.

Baseline: 1999-2000 IHS Oral Health Survey showed that 62% of 6-8 year olds had untreated decay and 67 % of 14-15 year olds had untreated decay

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also relates to the HP 2010 objective 21-2 (Oral Health: reduce the proportion of children, adolescents, and adults with untreated dental decay).

Program Performance: No FY 1999 Indicator

Family Violence, Abuse, or Neglect Indicator:

Indicator 16: During FY 2002 the IHS will assure that:

- a. at least 82% of I/T/U medical facilities (providing direct patient care) will have written policies and procedures for routinely identifying and following:
 - spouse/intimate partner abuse
 - child abuse and neglect
 - elder abuse or neglect

- b. at least 56% of I/T/U medical facilities will provide training to the direct clinical staff on the application of these policies and procedures.

Rationale: The purpose of this indicator is to help reduce the prevalence of family violence, abuse, and neglect by identification and referral for services. Victims of these conditions come to the health care system with a variety of physical injuries, illnesses or medical conditions directly related to abuse. The umbrella of family violence includes child, spouse or elder abuse and/or neglect. Experts in the field of family violence have identified an important link between violence against women and the abuse of their children. Research indicates that children who witness violence in the family are affected in the same way as children who are physically and sexually abused (Goodman and Rosenberg, 1987). The propensity for family violence can extend to older members of the family (parents, grandparents, aunts, uncles) living in the home. The consequences of family violence can be seen in physical, psychological and cognitive results such as intentional and unintentional injuries, detachment, avoidance, depression, and suicidal ideation.

Thus, the approach of this indicator is to increase the likelihood that providers consistently screen for indications of violence, abuse or neglect and making appropriate referrals. The written protocol makes this more likely because these efforts become part of the local quality assurance process. However, successful implementation of such a process also depends on staff training as well as cooperation from tribes and local governing bodies and thus requires resources and time. In the future, training will be part of the target measure for this indicator.

Approach: The Mental Health and Social Service program will work with IHS Area Offices to assure that staff members are appropriately trained and local policies and procedures are established for these health concerns. Tribal and urban programs will also be encouraged to address these areas and IHS will respond to requests for assistance. Existing funds and staff will be utilized. Achievement of the indicator will increase local identification of family violence and referral for appropriate prevention services and treatment of family violence, including the perpetrators, the individual victims, as well as the families and communities that suffer the consequences.

Data Source: Annual survey and/or progress review by IHS Area and Headquarters staff.

Baseline: Determined in FY 1998 to be at 47%. At that time 31 of 66 IHS Service Units reporting had Policies and Procedures in place to address this indicator. A survey in FY 1999 of 223 clinics and hospitals showed that 64% had written policies and procedures for domestic violence.

Type of Indicator: Process and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 2.4 *Improve the Safety and Security of Children and Youth*, 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also addresses several HP 2010 objectives in Focus Area 15: Injury and Violence Prevention.

Program Performance: The fiscal year 2000 Indicator was to assure that at least 70% of I/T/U medical facilities with urgent care or emergency departments or services have written policies and procedures for routinely identifying, treating, and / or referring victims of domestic violence, abuse, or neglect (i.e. child, spouse, elderly). Performance on this indicator in FY 2000 was assessed through a survey of I/T/U health centers, village clinics, and ambulatory and hospital based facilities. This included facilities with and without urgent care and/ or emergency departments.

In 1999, a survey of 223 facilities showed that 64% had written policies for domestic violence. The FY survey was similar though more detailed about elder and/ or child abuse and was initially mailed to 314 hospital and ambulatory care sites. The overall response rate was 42 %; this includes the following break down:

- a. hospital based response rate of 49% (24/49)
- b. ambulatory facility response rate of 39% (107/265)

The above response rates are reflective of facilities with emergency and/ or urgent care centers. The questions were designed to assess different policies and procedures. Facilities with emergency rooms and/or urgent care centers that responded indicated the following compliance with written policies and procedures:

- a. spouse/ intimate partner abuse – 68%
- b. child abuse / neglect – 80%
- c. elder abuse/ neglect – 68%

Averaging these three categories give an aggregate rate of 72%. In addition, approximately 54% of these responding facilities offered staff training on child and elder abuse and neglect, as well as spouse/ intimate partner abuse.

On aggregate the IHS achieved this indicator lead by the high percentage of clinics having policies to address child abuse and neglect, but is behind the 70% level for spouse/ intimate partner abuse, as well as elder abuse and neglect. The reasons for this include the following:

- a. Lack of survey response- the method of survey should be changed next year to include follow-up phone calls, as well as an accessible on-line database for updating information about policies and procedures, and for verifying compliance with this indicator. Time frame for completion – 9/01
- b. Possible inaccurate information - throughout IHS, 100% of hospitals are Joint Commission on the Accreditation of Health Care Organizations (JCAHO) accredited. These facilities must have a compliance rate of 100% for policies and procedures in these three areas (as these policies and procedures are mandated by JCAHO). In addition, JCAHO recommends similar policies and procedures in ambulatory settings (as does National Council on Aging). There are substantial external pressures from credentialing bodies to achieve this indicator.
- c. Lack of prototype policies and procedures – the IHS Women's Health web site will soon function as a repository for 'prototype' policies and procedures for these three areas. At that time, we will send out a notification to clinical directors about the accessibility of this information on-line. Time frame for completion – 6/01

Information Technology Development Group:

The following three indicators address the development of improved automated data capabilities that support clinical care and performance measurement and include efforts to:

- develop test sites to expand automated GPRA clinical data extraction capacity for clinical GPRA measures
- expand distribution and use of the mental health and social services module of the RPMS system across I/T/U settings to improve performance management of behavioral health
- expand IHS compatible data management capabilities at urban Indian program sites to support the contribution of data to the larger IHS and tribal aggregations for planning and performance management efforts, including GPRA.

Note, this is a new FY 2002 and FY 2001 Indicator

Indicator 17: During FY 2002, IHS will

- Collect baseline data for any performance measures where electronic data collection was implemented in FY 2001,
- Complete and report on the pilot web-based training program
- Complete implementation of LOINC standards in IHS's clinical information system

Indicator 17: During FY 2001, IHS will:

- Conduct a pilot study at five sites to evaluate the potential of electronically extracting data from the RPMS to report on five clinical performance measures,
- Begin one or more intervention studies at appropriate sites to resolve data quality problems that are identified in this and previous studies,
- For any of these performance measures where the data quality is deemed to be sufficient to proceed, implement electronic data collection so that baseline data can be collected for FY 2002.

Rationale: This indicator serves as part of a long-term effort to expand the IHS capacity to derive GPRA performance data directly from clinical automated information systems. This will allow IHS to add new performance measures in the most cost-effective way and without imposing additional data collection burdens on health care staff. It will also support other IHS management efforts – delivering high quality clinical care, managing programs, quality improvement, efficient and effective billing, monitoring epidemiological trends, performing clinical research, etc. This effort is on the cutting edge of medical informatics. To our knowledge, no other healthcare organization, public or private, has developed a large enterprise-wide system that has the capacity to report on a wide range of clinical measures from existing clinical information systems.

Approach:

The IHS's Resource and Patient Information System (RPMS) is a comprehensive information system that integrates clinical, administrative, and financial data in healthcare facilities. The Patient Care Component of the RPMS is an automated system for the collection, storage, and output of data gathered and recorded on a variety of forms or directly into the system at the point of patient contact in the outpatient, inpatient, and field visit settings. It has been implemented with a basic level of uniformity at over half of over 500 IHS, tribal, and urban facilities. Key challenges to our efforts to extract data for performance measures electronically are:

- We need to extract information from over 500 different sites, each with their own, at least somewhat unique, clinical information systems/repositories.
- There are no any widely accepted, uniform standards for how many critical classes of clinical information are coded or stored anywhere throughout the healthcare industry.

- Approximately half of our over 500 sites are independently administered and managed tribal or urban sites, not directly managed by IHS.

It is likely that the currently existing data repository architectures and quality in our clinical information systems will already allow us to extract several clinical measures electronically with sufficient accuracy in the short term. We are also certain that many other measures cannot yet be derived electronically with sufficient accuracy because of difficulties in compiling data across facilities due to lack of data standards, or problems with the accuracy and completeness of the data in those systems.

To analyze this issue, we are performing a complex study that compares electronically-derived with manual-chart-review-derived measures for five potential clinical measures at five diverse sites. The data collection phase of that study is nearly completed and we have begun to analyze the data. Early draft results and conclusions from that study should be available by winter of 2001 with the final results being completed by the summer of 2001.

Data from this and other studies have already identified problems with both the appropriate recording of data by service providers and the entry of those data by data entry staff. IHS has already begun to implement a pilot web-based training for local facility staff to improve both the recording and entry of data. This intervention includes an evaluation component that will allow us to assess its effectiveness. This pilot intervention will be fully implemented by the winter of 2001. Early draft conclusions about its effectiveness should be available by the winter of 2001, with final results available by summer 2002.

Through the influence of HIPAA legislation and other public and private efforts, more national and international, uniform data standards are being and will be developed. For example, LOINC standards for laboratory and other data are now uniformly accepted by most of the healthcare industry and are being implemented within IHS. The IHS LOINC implementation is a process that will likely be complete within a year (fall 2001) and most facilities, which use the IHS PCC laboratory package, will likely have implemented these standards within the following year (fall 2002). With this standardization, our ability to compile laboratory and other data across facilities will be dramatically improved, thus expanding the number of clinical measures we could potentially perform electronically.

Throughout this process, as we identify performance measures where the data quality and availability of standards is deemed to be sufficient to proceed, we will promptly implement electronic data collection.

Baseline: To be determined by this Indicator

Type of Indicator: Process and Balance Scorecard: innovation and learning perspective

Linkages: Ultimately this objective will support the automated collection of all other clinical measures and contribute to 3.6 *Improve the Health Status of American Indians and Alaska Natives.*

Program Performance: Not applicable because this was not a FY 2000 indicator.

Indicator 18: During FY 2002, increase the number of I/T/U programs utilizing the Mental Health/Social Services (MH/SS) data reporting system by 5% over the FY 2001 rate.

Rationale: The purpose of this indicator is to improve planning, implementation and evaluation of mental health, alcohol and substance abuse, and social services efforts across I/T/U programs. The implementation of the MH/SS data reporting system will provide the vehicle for collection of baseline morbidity, mortality, services and workload data for IHS. Audits of the existing I/T/U data systems have documented both under-reporting and lack of specificity of mental health related conditions reported and services provided. Thus, the continued implementation of this management information system tool will provide a plethora of baseline information that will enhance and complement national private and public outcomes monitoring efforts and allow consistent reporting, data aggregation for planning, managed care, and more effective billing and collection for services. This objective is also essential for monitoring many of the HP 2010 objectives addressing "Mental Health and Mental Disorders."

Approach: Accomplishment of this indicator is contingent on several factors. The implementation of the RPMS data system should be mandatory and a priority within the IHS service system. Responsibility for the maintenance of the data system will be shared by the MH/SS program and Division of Information Resources, to assure clinical, technical and administrative viability. The proposed implementation level of an addition 5 percent of I/T/U sites is based on the resources available to provide the incremental hardware and software upgrades, as well as staff training.

Data Source: MH/SS component of RPMS. Each year a survey with a preformatted spreadsheet is sent to all 12 I/T/U areas information system coordinators (ISCs) to complete and update as more programs come online with the MH/SS package. Also, the IHS Indian Health Performance Evaluation System (IHEPS) and ORYX project has built a SAS dataset to analyze data that is extracted to the national IHS data center.

Baseline: FY 2001 level available January 2002

Type of Indicator: Process and Balance Scorecard: innovation and learning perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 2.4 *Improve the Safety and Security of Children and Youth*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. This indicator also supports several HP 2010 objectives in Focus Area 18: Mental health and Mental Disorders.

Program Performance: The FY 2000 performance measure was to increase the percent of I/T/Us that have implemented the use of the MH/SS data reporting system by 10% over the FY 1999 level that was 51%. This measure was not achieved, with 115 of 227 I/T/U programs or 51% having implemented this system according to Area Information Systems Coordinators. The breakdown by type of program is 85% for IHS run programs, 35% for tribal programs, and 60% for Indian urban programs. Expanding the use of this system continues to be a crucial

component of the overall Behavioral Health efforts throughout the IHS, including tribal and urban programs.

A major setback in not achieving this goal is that a new version of the MH/SS MIS package, which combines relevant data items from the Chemical Dependency MIS and the MH/SS MIS was not tested and implemented in FY 2000, as had originally been planned. In the I/T/U areas a Behavioral Health MIS, with the capacity to capture chemical dependency, mental health, and social services data would be accepted.

Plans to improve this indicator is to follow through on the testing and implementing of the new Behavioral Health MIS in FY 2001, with plans to fully implement this package in FY 2002. Expanding the use of this system continues to be a crucial component of the overall Behavioral Health efforts throughout the IHS, including tribal and urban programs.

Indicator 19: During FY 2002, increase by 10% the proportion of Urban Indian health care programs that have implemented mutually compatible automated information systems which capture health status and patient care data over the FY 2001 level.

Rationale: The purpose of this indicator is to assure that Urban Indian Health programs develop automated health information systems that support local health program needs as well as provide data for the larger IHS requirements, including GPRA. Adequate health status and health services data are essential for the effective planning and management of any health care delivery system. Currently Urban Indian health programs capture data under the Urban Common Reporting Requirements (UCRR). These data are not currently compatible with other IHS health services data sets and only of limited use for the purpose of health systems management. Thus, the large urban AI/AN population has been minimally represented in AI/AN data sets.

Approach: A workgroup has been formed, comprised of Urban Programs health directors to review and revise the UCRR. The revised UCRR will capture an expanded set of data that are compatible with the IHS RPMS System, as well as provide local urban program managers better information about the health status and health services provided to their clients. Until a comprehensive needs assessment is completed it is difficult to estimate the resource requirements of this project; however, attempts will be made to, where feasible, avail the IHS RPMS system to urban programs so that systems are not duplicated. These indicators were developed to help monitor successful development of then updated urban data reporting system. The proposed implementation of a 10% increase is based on a schedule to provide the incremental hardware and software upgrades as well as urban program staff training.

Data Source: Self-report of Urban health programs.

Baseline: FY 2001 level available January 2002

Type of Indicator: Process and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's*

Population and directly addresses the HP 2010 objective 23-4 (Public Health Infrastructure: data for select populations).

Program Performance: The FY 2000 performance measure was to assure that by the end of FY 2000 the Urban Indian Health Program would have field tested in at least one site, a mutually compatible automated information system that captures health status and patient care data. This was accomplished when the Seattle Indian Health Board successfully completed the field test of a mutually compatible automated information system. In addition, at least six programs within the California area have transmitted data electronically during FY 2000. Another major accomplishment of FY 2000 was the installation of local area networks within at least 20 Urban Program sites, thus creating connectivity between the agency and the individual urban programs. The connectivity provided for 100% compliance of reporting of the Urban Common Reporting Requirements transmitted electronically by each individual program.

Quality of Care Group:

The following two indicators address the quality of health care provided in IHS settings from both the perspective of accreditation and consumer satisfaction.

Indicator 20: During FY 2002, maintain 100% accreditation of all IHS hospitals and outpatient clinics.

Rationale: The accreditation of IHS hospitals and clinics represents perhaps the most objective and respected measure of health care quality and thus the inclusion of this indicator is self-evident. In addition, accreditation is essential for maximizing third-party collections, and contributes directly and indirectly to many other indicators presented in this plan.

Approach: The local I/T/U multidisciplinary team approach to accreditation and ongoing quality management has been the mainstay of success in this important activity. Additional support and guidance from Areas and Headquarters staff will continue to support this indicator. This will be one of the most demanding indicators to meet given the growing clinical quality of care assessments that are required as well as issues related to health facilities maintenance, improvement, and renovation that are critical to accreditation. The accrediting body used for hospitals and some ambulatory health centers is the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). However, there was an increase in the ambulatory health centers that obtained accreditation from the American Association of Ambulatory Health Centers (AAHC).

Data Source: IHS compiled database generated from accreditation reports submitted by IHS Area Quality Assurance coordinators.

Baseline: 100% accreditation of IHS hospitals and outpatient clinics for FY 1999 and FY 2000.

Type of Indicator: Process and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Goal 4, *Improve the Quality of Health Care and Human Services*, and Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives* and broadly supports several HP 2010 objectives in Focus Area 1: Access to Quality Health Services.

Program Performance: The FY 2000 indicator committed to maintaining 100% accreditation of all IHS hospitals and outpatient clinics. This indicator has been achieved. During FY 2000, eight IHS hospitals were evaluated by JCAHO and all eight maintained full accreditation with seven of the eight improving their score from their previous accreditation assessments and one hospital achieving the same score as their previous evaluation. In addition, 15 ambulatory health centers participated in accreditation visits from JCAHO and AAAHC and all were accredited, with five being accredited for the first time.

Indicator 21: During FY 2002, establish baseline health care consumer satisfaction levels for all IHS Areas using an approved instrument.

Rationale: The intent of this indicator is to improve consumer satisfaction. Assessing consumer satisfaction is fundamental to quality management, assuring improved customer satisfaction, and required for accreditation of hospitals and clinics.

Approach: In FY 1999 the IHS developed a comprehensive culturally sensitive consumer satisfaction survey instrument that was based on a tested and validated instrument from the private sector. In FY 2000 the instrument and data collection protocol were to have completed the Paperwork Reduction Act clearance process and to be used to identify baseline scores for IHS hospitals and clinics. However, the submission package was delayed in completion and will not reach OMB until mid FY 2001. With clearance not anticipated until late FY 2001, the baseline assessment will not be complete until FY 2002.

The responsible parties for implementation are the local I/T/U service sites with assistance from the IHS Area office staff. The local staff will be part of the local quality assurance program and the aggregate staff will be part of the IHS epidemiology centers/program.

Data Source: IHS Consumer Satisfaction Survey

Baseline: To be determined with initial FY 2002 survey

Type of Indicator: Process and Balance Scorecard: customer perspective

Linkages: These indicators support the DHHS Strategic Plan, Goal 4, *Improve the Quality of Health Care and Human Services*, and Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives*.

Program Performance: The FY 2000 indicator was to submit a pre-tested culturally sensitive consumer satisfaction instrument for clearance through the Paperwork Reduction Act process by the end of FY 2000 and secure a baseline assessment. The Indian Health Services has made limited progress the effort to develop and implement a patient satisfaction survey. The step to obtain full approval of the instrument moved forward after receiving no public comments from the 30 and 60-day Federal Registry Notices publications. An additional delay occurred with the process when the Agency clearance officer put a revision of the questionnaire forth for consideration. Questions on this issue are currently in the process of being resolved. The remaining component of the survey instrument to be completed is a revision of the instruction for use by the area liaison when the survey instrument is implemented.

**Performance Summary Table 2:
Prevention Indicators**

Performance Indicator	FY Targets	Actual Performance	Reference
Public Health Nursing Indicator			
Indicator 22: Increase the number of public health nursing services (primary and secondary treatment and preventive services) provided to infants and elders.	Total Visits FY 02: +2% over FY 01 FY 01: +3% over FY 00* FY 00: 7% over 97 or 363,033 FY 99: no indicator Home Visits FY 02: +2% over FY 01 FY 01: +3% over FY 00* FY 00: 7% over 97 or 127,846 FY 99: no indicator	FY 02: FY 01: FY 00: 371,548** (9.5 % over FY 97) FY 99: 336,134 FY 97: 339,283 baseline FY 02: FY 01: FY 00: 127,873** (7% over 97) FY 99: 111,836 FY 97: 119,482 baseline	P: p. 81 B: p. IHS-73 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130. ** provisional data pending final verification
Immunization Group			
Indicator 23: Increase the proportion of AI/AN children who have completed all recommended immunizations by the age two.	FY 02: +1% over FY 01 level FY 01: +1% over FY 00 level* FY 00: +2% over FY 99 level FY 99: 91%	FY 02: FY 01: FY 00: 86% 12 of 12 Areas (-3%) FY 99: 89% 12 of 12 Areas 87% 11 of 12 Areas FY 98: 88% (baseline 11 of 12 Areas)	P: p. 83 B: p. IHS-27 p. IHS-85 p. IHS-73 p. IHS-81 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 123-130.
Indicator 24: Increase overall pneumococcal and influenza vaccination levels among diabetics and adults aged 65 years and older.	Influenza FY 02: +1% over FY 01 level FY 01: +1% over FY 00 level* FY 00: 65% FY 99: no indicator Pneumococcal FY 02: +1% over FY 01 level FY 01: secure electronic baseline* FY 00: 65% FY 99: no indicator	FY 02: FY 01: FY 00: 30.7% new electronic sample baseline FY 98: 63% baseline from diabetes audit FY 02: +1% over FY 01 level FY 01: FY 00: data source inadequate FY 99: FY 98: 63% baseline from diabetes audit	P: p. 84 B: p. IHS-27 p. IHS-85 p. IHS-73 p. IHS-81 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.

Performance Indicator	FY Targets	Actual Performance	Reference
Injury Prevention Group			
Indicator 25: Expanding the number of tribes/tribal organizations with comprehensive injury prevention programs	FY 02: 30 sites FY 01: no indicator FY 00: no indicator	FY 02: FY 01: FY 00: baseline 25 sites	P: p. 86 B: p. IHF-39
Indicator 26: Reduce the number of unintentional injuries for AI/AN people.	<u>Hospitalizations</u> FY 02: 2% under FY 01 level FY 01: 70 per 10,000 FY 00: 71.5 per 10,000 <u>Deaths</u> FY 99: 93/100,000	FY 02: FY 01: FY 00: 05/01 FY 98: 72.5 /10,000 hosp. FY 96: 74.7/10,000 hosp. FY 99: 12/02 FY 94-96: 92.6/100,000 deaths FY 92-94: 95.0/100,000 deaths	P: p. 87 B: p. IHF-39 p. IHS-73 p. IHS-81
Suicide Prevention Indicator			
Indicator 27: Increase percentage of I/T/Us that have implemented a suicide surveillance system to monitor the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions) which assures those at risk receive services, and that appropriate population-based prevention interventions are implemented.	FY 02: + 10% over FY 01 level FY 01: 50% of I/T/Us implem. FY 00: no indicator FY 99: no indicator	FY 02: FY 01: FY 00: 05/01 FY 99: FY 98: estimated 25%	P: p. 89 B: p. IHS-41
Pilot Prevention Group			
Indicator 28: Collaborate with NIH and AI/AN sites in developing and implementing culturally sensitive community-directed pilot cardiovascular disease prevention programs.	FY 02: 3 sites implementing interventions FY 01: 3 sites with intervention plan* FY 00: no indicator FY 99: no indicator	FY 02: FY 01:	P: p. 90 B: p. IHS-109 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 29: Maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites, as part of an overall assessment of the ongoing childhood obesity prevention project's effectiveness.	FY 02: continue implementation and access community acceptance FY 01: implement program and monitor pilots and comparisons sites FY 00: establish five pilot sites FY 99: develop approach and baselines	FY 02: FY 01: FY 00: pilot sites established FY 99: approach and baseline accomplished	P: p. 92 B: p. IHS-27 p. IHS-109 p. IHS-129 p. IHS-73 p. IHS-81

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 30: Develop at least five regional tobacco control centers to assist AI/AN health facilities and organizations with tobacco prevention and cessation activities.	FY 02: commence all prescribed control activities in 5 sites FY 01: establish five tobacco control centers FY 00: establish baseline rates for tobacco usage FY 99: no indicator	FY 02: FY 01: FY 00: baseline rates established	P: p. 94 B: p. IHS-27 p. IHS-109 p. IHS-141
HIV/AIDS Group			
Indicator 31: Maintain ongoing surveillance of HIV/AIDS and determine the level of completeness of reporting	FY 02: six Areas assessed FY 01: one Area assessed FY 00: establish baseline rates FY 99: no indicator	FY 02: FY 01: FY 00: partially established	P: p. 96 B: p. IHS-27 p. IHS-109 p. IHS-141
Indicator 32: Increase the percentage of high risk sexually active persons who know their HIV status and have received risk reduction counseling.	FY 02: +10% over baseline FY 01: Establish baseline FY 00: no indicator FY 99: no indicator	FY 02: FY 01: FY 00: no baseline	P: p.97 B: p. IHS-109 p. IHS-141
Environment Surveillance Indicator			
Indicator 33: Develop environmental health surveillance system. And complete community environmental assessments in AI/AN communities.	FY 02: +10% over FY 01 level FY 01: 15% of communities assessed* FY 00: develop surveillance protocol and plan FY 99: no indicator	FY 02: FY 01: FY 00: protocol and plan partially completed FY 99: no surveillance systems in place	P: p. 198 B: p. IHF-39 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Total Prevention Funding :	FY 02: \$118,224,000 FY 01: \$113,558,000 FY 00: \$109,216,000 FY 99: \$102,712,000 FY 98: \$99,647,000		P: page # in perform. plan B: page # in budget justif.

B. FY 2002 Prevention Indicators:

Public Health Nursing Indicator:

Indicator 22: During FY 2002, increase by 2% the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits over the FY 2001 workload levels.

Rationale: The purpose of this indicator is to improve the health status of AI/AN people through improved access to services associated with improved health outcomes. Public Health Nursing (PHN) is the integration of nursing practice and public health practice applied to the prevention of disease and the promotion and preservation of the health of Indian population. The nature of this practice is continuous and comprehensive, including all program areas and diagnostic groups. It includes primary and secondary treatment and preventive services, counseling, education, community development and referral follow-up. Many of the successes in Indian health such as decrease in infant mortality, high immunization rates, and increased prenatal care are attributed to the efforts of public health nursing.

The unique quality of PHN service is that care can be provided in any setting where the patient is accessible. This is especially effective for high-risk patients and families (e.g., substance abusing prenatal patients, communicable disease cases, families with dysfunctional life styles, etc.). Settings include homes, schools, jails, bars, and other community locations in addition to the health clinic. The ability to meet the patient in their own environment allows the PHN to fully assess socioeconomic and quality of life variables that affect health status and facilitates rapport with patients who often distrust the formal health care system.

Causes of health problems are multi-factorial and interventions must be multidimensional in order to be effective. Measuring the direct impact of public health nursing services can be accomplished in a variety of models. Many of the GPRA indicators (diabetes, prenatal care, immunizations, well child care, obesity) require a strong public health nursing contribution in order to be successful and to demonstrate evidence-based outcomes. The impact of home visiting with education and counseling services is more challenging to directly measure. Home visiting is generally accepted as a means to improve access to care and to impact on health status of individual patients, families and the community as a whole. Research ("Home Visitation and Maternal and Child Health – Kitzman et al, *Journal of the American Medical Association*, August 27, 1997 and "Enduring Effects of Nurse Home Visitation on Maternal Life Course – Kitzman et. al., *Journal of the American Medical Association*, April 19, 2000) supports this contention and concludes (after extensive controlled trials in which multiple outcome indicators were studied) that a "program of home visitation by nurses can reduce pregnancy-induced hypertension, childhood injuries, and subsequent pregnancies among low-income women". Other research (Long-term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behavior – Olds et.al., *Journal of the American Medical Association*, October 14, 1998) shows that adolescents born to women who received nurse visits during pregnancy and postnatally and who were unmarried and from households of low socioeconomic status (risks for antisocial behavior) reported fewer instances of running away, fewer arrests, fewer convictions and violations of probation, fewer cigarettes smoked, and fewer days of having consumed alcohol. Therefore, public health nursing workload, especially community based visits and home

visits, is used as measure of program effectiveness and an overall indicator of health status of the community.

Approach: The population base for public health nursing services is the IHS census population residing within the official boundaries of the Area. The PHN/RRM standard indicates that PHN program addresses the needs of the community and therefore the appropriate target population is census population. However in some service units, the user population is greater than the reported census population. In these cases, the Indian user population is used as an estimate of the service population to reflect PHN service to both stable community and transient populations.

Providing access to PHN services is directly dependent upon the availability of community-based resources, particularly recruiting and retaining PHN providers. Strategies for increasing access to care and marketing healthy life style behaviors includes targeting high-risk patients based on community epidemiological data. Newborns, infants, pregnant women, and elders are targeted high risk populations in Indian communities both from an individual perspective based on their high-risk status and from a psychosocial perspective based on their contributions to healthy family and community life.

Baseline: FY 2001 workload data will be verified using RPMS procedures described on page 121 and analyzed to define the baseline for the objective. IHS nursing staff is currently working with data management staff to refine data collection and analysis processes which would allow workload breakdown by both age categories (newborn, infant, elder) and by diagnostic category (teen pregnancy, family planning, anticipatory guidance to parents, SIDS prevention, health promotion for the elderly wellness). This will provide a more in-depth perspective of the breadth of public health nursing services and the targeting of high-risk populations.

Data Sources: IHS PCC, IHS Program Statistics Team, and written reports submitted by Tribes using non RPMS systems.

Type of Indicator: Process/Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It also broadly supports a multitude of HP 2010 objectives.

Program Performance: The FY 2000 performance indicator committed to increasing the total number of Public Health Nursing services and the number of home Public Health Nursing visits to the AI/AN population by 7% over the FY 1997 level. This indicator was met based on comparison of the FY 1997 and FY 2000 Public Health Nursing productivity reports. In FY 1997, the total Public Health Nursing visits were 339,283 and the home Public Health Nursing visits were 119,482. The FY 2000 Public Health Nursing report reflects that 371,548 total Public Health Nursing visits were provided (9.5% increase) and 127,873 home Public Health Nursing visits were provided (7% increase).

Immunization Group:

The following two indicators support immunization coverage in children and adults at high risk for preventable diseases and represent perhaps the most efficacious "impact" interventions known to public health.

Indicator 23: During FY 2002, increase the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months as recommended by the Immunization Practices Advisory Committee (ACIP) of the U.S. Public Health Service by 1% over the FY 2001 level.

Rationale: The purpose of this indicator is to reduce the incidence of preventable diseases in children. Immunizations are one of the most cost-effective public health measures available for improving health outcomes in children and are a recognized standard of care and immunization rates are a recognized standard of public health. Thus, vaccination coverage rates are a sensitive measure of the status of public health services and are essential to the IHS Mission.

Approach: Percent of children vaccinated appropriately for age will be calculated for the IHS service population of children from each Area. Vaccines evaluated include polio (IPV), Diphtheria/Tetanus/Pertussis (DTaP), Measles/Mumps/Rubella (MMR), Haemophilus influenzae type b (HIB), Hepatitis B (HBV), and Hepatitis A (HAV). IHS continues to rely on a system of complete ascertainment. This system is supplemented by periodic statistically valid sampling to establish more reliable coverage estimates. IHS will be primarily responsible for completing the surveys.

Data Source: IHS patient care records and public health nursing records.

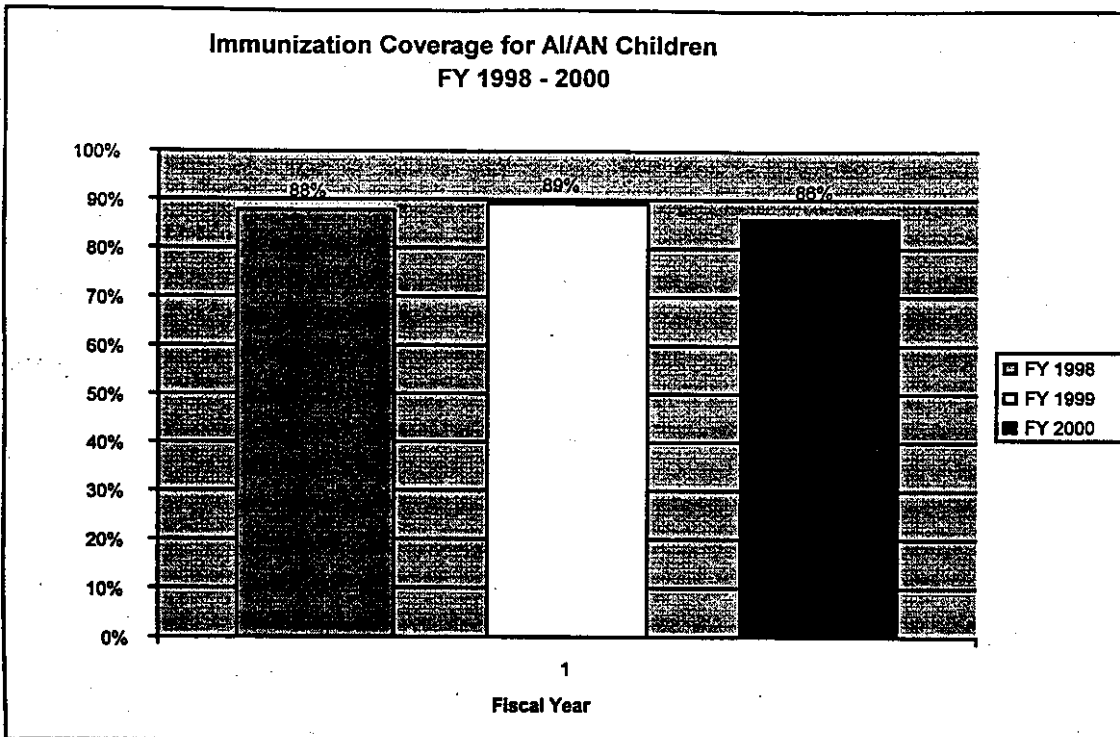
Baseline: 89% based all 12 Areas.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It also directly addresses the HP 2010 objectives in Focus Area 14: Immunizations and Infectious Diseases.

Program Performance: The FY 2000 performance indicator was to increase by 2% over the FY 1999 rate the proportion of AI/AN children who have completed all recommended immunizations by the age of two. As the FY 1999 rate was 89% for all 12 Areas, the goal for FY 2000 was to achieve 91% coverage. Based on quarterly reports from all 12 IHS areas for FY 2000, the proportion of AI/AN children who completed all recommended immunizations by 27 months was 86%; the FY 2000 performance measure of 91% was not achieved. Reasons for not meeting the FY 2000 performance indicator include:

- general problems with the infrastructure to deliver vaccines, such as vacancies in positions essential for the delivery, tracking and reporting of immunizations (i.e. public health nurses, medical records staff)
- reduced emphasis on immunizations in generalized primary care settings because of growing urgent care demands
- increasingly complex immunization schedules as new vaccines are added
- incomplete tracking due to the multiple sources of health care (many non-IHS)
- IHS immunization computer program not fully utilized at many local facilities



Steps taken to address challenges:

- IHS is addressing agency-wide recruitment and retention problems
- target funding toward improving immunization coverage levels.
- development of immunization information materials specific to AI/AN communities in order to educate parents on the importance and safety of new vaccines is on-going.
- eliminate barriers to effective utilization of IHS computer program for local tracking of immunizations.
- efforts to work with states to facilitate data exchanges with IHS facilities for the purpose of developing state-wide immunization registries and improve immunization tracking across health care facilities (both IHS and non-IHS) are underway.

Indicator 24: During FY 2002, increase pneumococcal and influenza vaccination levels among adults aged 65 years and older by 1% over the FY 2000 level.

Rationale: The purpose of this indicator is to reduce the incidence of vaccine-preventable diseases in adults and elders. Immunizations are one of the most cost-effective public health measures available for improving health outcomes. In addition, adult vaccination coverage rates are a sensitive measure of the status of clinical preventive services and are essential in supporting the IHS Director's elder health project. This indicator also directly supports the HP 2010 "Immunizations and Infectious Disease" objectives.

Approach: The IHS follows the recommendations of the Immunization Practices Advisory Committee (ACIP) of the U.S. Public Health Service. Recommendations for prevention and control of influenza change yearly depending on a number of factors such as global monitoring of influenza virus activity and experiences from the prior influenza season. In 2000, the age for universal adult influenza immunization was lowered from 65 years to 50 years of age. IHS has not implemented new programs aimed specifically at immunizing adults age 50 to 64 years,

therefore the current HP 2010 target of influenza vaccination for 90% of adults 65 years of age remains as the overall program goal. Recommendations for prevention and control of pneumococcal disease have not changed, although the minimum age for universal immunization of AI/AN includes all ages in many AI/AN communities. By FY 2002 pneumococcal conjugate vaccine (PCV7) may be recommended for adults. Until ACIP changes recommendations, however, IHS continues to focus on the most at-risk age groups for pneumococcal disease, including adults 65 years of age. Implementation of ACIP recommendations is undertaken at the local level by clinicians, nurses, and public health nurses with guidance from Area Immunization Coordinators under direction of the IHS National Immunization Coordinator. Recent recommendations by ACIP suggest that standing orders programs that authorize nurses and pharmacists to administer vaccinations according to an institution- or physician-approved protocol without a physician's exam may improve adult immunization rates.

Data Source: The immunization rate for influenza was determined from a simple random sample of 5000 electronic medical records of all AI/AN over age 65 (N=80,454) from the NPIRS (National Patient Information Resource System). All records in the sample were scanned for any record of influenza immunization. This immunization coverage rate includes adult AI/AN who received their influenza vaccination only at an IHS facility. There is often no documentation of adult immunizations received in nontraditional settings such as churches and pharmacies. FY2000 was the first year that we have attempted to measure immunization rates among all adults; in previous years we have only determined rates in the population with diabetes. The FY1998 baseline immunization rate among adults with diabetes was 63% (data from the Annual Diabetes Care Audit). Because of their more intensive clinical monitoring and high-risk status, it is not appropriate to use the immunization rate among diabetics as a baseline for the rates in the general population. It is likely, however, that many AI/AN receive the flu shot from nontraditional sources outside the IHS medical record system.

Coverage rates for pneumococcal vaccination will require a different strategy given that current recommendations call for vaccination every five years in adults over 65 years of age. This year our focus was on developing and evaluating use of statistical sampling for a small subset of indicators. We are currently developing a technique to sample and evaluate adults for receipt of pneumococcal vaccination. Our plan is to include an evaluation of pneumococcal coverage in FY2002.

In addition to exploring ways to capture immunization information from non-IHS sources, we are conducting a manual chart review of a subset of this sample to verify and measure the validity of our electronic medical records in order to determine the suitability of this method for subsequent GPRA reports.

A recent review of adult immunization rates in Alaska showed that the rate determined by electronic records was 29%, the rate by manual chart review was 59%, and the rate by chart review plus phone call was 78%.

Baseline: FY2000 was the first year that we attempted to measure immunization rates among all adults using statistical sampling of the NPIRS database. FY2000 and 2001 will be used to establish a baseline measure once the methodology has been verified and validated.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 2.5 *Increasing Opportunities for Seniors to Have an Active and Health Aging Experience*, 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. It also directly addresses the HP 2010 objectives in Focus Area 14: Immunizations and Infectious Diseases.

Program Performance: The FY2000 performance indicator was to increase the overall pneumococcal and influenza vaccination levels among adults over 65 by 2% over the 1998 rate. As explained above, the FY 1998 baseline was not considered representative and a reliable baseline for comparison was not possible with our available systems during FY 1999. However, we have established a new electronic sample derived baseline for FY 2000:

- 30.7% of all AI/AN over 65 were vaccinated against influenza.

Pneumococcal immunization, which is only recommended once every 5 years, is more difficult to ascertain from IHS electronic medical records and we were not able to develop a baseline. Our approach for FY 2001 is to pilot and validate methods using influenza vaccination. Based on the outcome of these studies we will begin measuring pneumococcal vaccination rates to establish a baseline in FY 2001. In addition, because recommendations for receipt of these two vaccinations are subject to frequent change by ACIP, the indicator may be more appropriate if made in the form of a running three-year average of improvement toward the overall goal of 90% vaccination coverage.

Injury Prevention Group:

The following two indicators address the process and outcome of comprehensive community-based injury prevention efforts across I/T/U settings.

Indicator 25: During FY 2002, expand the number of tribes/tribal organizations that meet the criteria standards of IHS comprehensive injury prevention programs from the baseline of 25 tribes in FY 2000 to at least 30.

Rationale: The purpose of this indicator is to reduce injury rates in the AI/AN population by the expansion of community based prevention technologies. Beginning in the early 1970s the IHS began a public health campaign to address this leading killer of AI/ANs. The early prevention efforts were based upon established Health Education/Health Behavior theories. Despite some success in raising awareness and some changes in human behavior, it was clear that a comprehensive public health approach would be needed to make a significant impact. The program began an aggressive injury surveillance effort in the early 1980s that created and empowered community coalitions and implemented evidenced-based strategies. The next and final step to this 30-year history in Indian Injury Prevention was the application of a community capacity building approach with the intent of developing the local public health capacity of tribes to significantly reduce injuries in their community's settings. This systematic process includes training, core-funding base, partnerships, implementing interventions, and technical assistance as needed.

These efforts have contributed to over a 50 percent reduction in unintentional injury related deaths between 1973 and 1993 and the expansion of the community capacity building approach is thus justified and represents the primary means to accomplish Indicator 26.

Approach: In FY 2000 IHS awarded approximately \$1.25 million dollars to tribes to establish comprehensive injury prevention programs. This was part of the IHS Five Year Strategic Plan for Injury Prevention. These approximately 25 new programs will receive \$50,000 per year for 5 years to hire a full time injury prevention coordinator, form an injury prevention advisory group, conduct basic injury surveillance, form partnerships, and begin to implement strategies to target those at risk for injuries, such as occupant protection, impaired driving, house fires, domestic violence, etc. Because technical assistance and support is so critical to new programs, IHS Area and District Injury Prevention Specialists will be engaged partners with these new tribal programs, and provide expertise in training, injury data collection, and evaluation. Experts in the field of community-based injury prevention will also be hired to provide technical assistance and support to all new tribal injury prevention programs.

Data Sources: Determining the implementation of comprehensive injury prevention programs will be determined from the use of a criteria-based survey of local I/T/U by each IHS Area Injury Prevention Specialist.

Baseline: 25 tribal programs in FY 2000 based on preliminary survey.

Type of Indicator: Process and Balance Scorecard: internal perspective

Linkages: These indicator supports the DHHS Strategic Plan, Strategic Objectives 1.2 *Reduce the Number and Impact of Injuries*, and 3.6 *Improve the Health Status of American Indians and Alaska Natives*. It also directly addresses the HP 2010 objectives in Focus Area 15: Injury and Violence Prevention that relate to unintentional injury prevention.

Program Performance: New indicator for FY 2002

Indicator 26: During FY 2002, reduce injury-related hospitalizations for AI/AN people by 2% over the FY 2001 level.

Rationale: Injuries are a leading cause of hospitalization for AI/AN people relative to morbid events. Annually, forty six percent (46%) of the Years of Potential Life Lost (YPLL) for AI/AN people are the result of injuries. Furthermore, injuries are the number one cause of mortality for AN/AN people for ages 1-44 years and second for overall death rates. The IHS spends more than \$150,000,000 annually for the treatment of non-fatal injuries. The single largest expenditure of contract medical care funds is for the treatment of injuries. However, the systematic implementation of safety protocols through partnerships with tribes and outside agencies has demonstrated significant improvements in injury rates across AI/AN communities and will serve as models for further diffusion of these technologies.

Approach: The IHS has assigned a Principal Injury Prevention Consultant, in the Office of Public Health, at Headquarters who coordinates activities and resources with specially trained Injury Prevention Specialists at the Area, District, Service Unit and tribal levels. This program employs a community empowerment model based upon Dr. John Farquar's work at Stanford University (1985). Primary program emphasis is directed to building the capacity of tribes to recognize severe injury problems and employ evidence-based strategies to prevent or otherwise control injury outcomes. The Complete Injury Prevention Program model developed by IHS is the cornerstone of community-based intervention measures.

The IHS Five-Year Injury Prevention Strategic Plan identified the need for basic capacity building and investments in tribal and Federal infrastructures for the development of effective injury prevention programs. Since 1990, over \$3.5 million has been appropriated to injury prevention programs and competitively based intervention projects. In 1997 the Director, IHS, supported a national demonstration grant announcement for basic public health infrastructure projects within tribes. Approximately \$300,000 is awarded for the 13 tribal project sites. In addition to these projects, literally hundreds of Indian communities and Alaska Native villages are implementing proven injury prevention strategies associated with safe home and communities.

Most of the unintentional injury problem is related to motor vehicle crashes. Significant improvements can be made in these statistics with increases in use of occupant protection [safety belts and child safety seats], reducing pedestrian/motor vehicle collisions and reductions in alcohol-related injuries through multiple strategies including corrections in the physical environments, changes in tribal policies and health promotion/education. These injury measures are identified in the HP 2010 Objectives and are relatively easy to measure.

In FY 2000 IHS will be implementing a \$1 million dollar cooperative agreement program with tribes to establish local injury prevention programs to address injuries. Other new projects are targeting childhood fire-related deaths through the *Sleep Safe* program in conjunction with Head Start schools, and continued work with our partners such as the Centers for Disease Control, the National Highway Traffic Safety Administration, the Maternal and Child Health Bureau at HRSA, and the US Fire Administration.

Data Source: In its original form from the FY 1999 performance plan, this indicator targeted injury mortality as the performance measure. However, due to the time lag of 2-3 years in the release of official injury mortality data from the National Center for Health Statistics (NCHS), IHS has determined that injury-related hospitalization rates are a more appropriate measure for the rate of unintentional injuries and will use this measure for the FY 2000 and FY 2001 indicators.

By using this approach the lag time in obtaining data can be shortened to less than one year as compared to the NCHS mortality data. In addition, these data include hospital discharges for IHS tribal and contract health care facilities and thus are considered inclusive. Finally, it is likely that the injury hospitalization rate may actually be more sensitive to the actual injury rates than mortality because improvements in emergency medical services could improve injury mortality without reducing the actual injury rate or morbidity.

Baseline: Estimated to be 72.5 per 10,000 in FY 1998 for AI/AN population on or near reservations.

Type of Indicator: Outcome and Balance Scorecard: internal perspective

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 1.2 *Reduce the Number and Impact of Injuries*, and 3.6 *Improve the Health Status of American Indians and Alaska Natives*. It also directly addresses the HP 2010 objectives in Focus Area 15: Injury and Violence Prevention that relate to unintentional injury prevention.

Program Performance: The FY 1999 measure for this indicator was to assure that the injury death rate was no greater than 93 per 100,000 deaths in the AI/AN population. While the data that is currently available is incomplete, it is highly likely that this measure has been met and possibly/probably exceeded. When the measure was initially set in FY 1998, the most recent rate available was 95 per 100,000 based on 1992-94 NCHS data. However, the FY 1994-96 data that became available last year showed that the rate had dropped to 92.6 per 100,000. Because of difficulties and delays in getting mortality data that we initially had hoped to overcome, we changed the indicator for FY 2000 and FY 2001, as described above, to focus on hospitalizations.

Regardless of how injuries are measured, the community-based joint partnership approach that has been used has proven successful, as injuries (unintentional and intentional) have dropped from the leading cause of death for Indian people of all ages in the early part of the decade to the 2nd leading cause of death currently (heart disease is now the leading cause for all ages). And while seven IHS Areas still have rates that are above the FY 1999 mortality target, most of these areas are in the rural west, such as the Navajo and Aberdeen Areas, where travel distances are long and residents are at high risk for motor vehicle-related injury. However, these Area rates have been trending downward over time, due to efforts in reducing pedestrian/motor vehicle crashes, tribes passing tougher drunk driving and occupant restraint laws, and stricter enforcement of these laws.

Suicide Prevention Indicator:

Indicator 27: During FY 2002, increase by 10% over the FY 2001 level, the proportion of I/T/Us that have implemented systematic suicide surveillance and referral systems which include:

- a. monitoring the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions)
- b. assuring appropriate population-based prevention interventions are implemented and those identified at risk receive services

Rationale: This indicator is part of an expanding systematic effort at reducing the prevalence of suicide in the AI/AN population. The suicide death rate for the AI/AN population has actually increased in the 1990s and is currently 72% greater than the national average. This problem has been particularly devastating for a number of AI/AN communities that have experienced dramatic increases in adolescent suicides in recent years and represents one of the greatest tragedies the IHS must address. The implementation of local suicide surveillance and prevention projects has been successful in reducing suicide acts in several Indian communities. The obvious goal of diffusing intervention approaches and learning from successful programs to other AI/AN settings is to reduce suicide acts in the AI/AN population as quickly as possible.

Approach: The I/T/Us will be responsible for reporting the implementation of protocols via survey to be conducted by the Division of Clinical and Preventive Services, Office of Public Health. Resources for analysis may be required from other divisions within the Office of Public Health. A suicide surveillance and prevention system was developed in the Albuquerque IHS Area (National Suicide Prevention Project with the Center for Disease Control and Prevention). A suicide surveillance instrument that identifies potential high-risk individuals has been developed and is currently being used in clinics and case management systems have been

piloted. Numerous clinics, hospitals and behavioral health programs are currently using suicide surveillance protocols and now simply need to be identified and counted. A suicide surveillance and prevention system is being encouraged for use in I/T/Us to assure the routine suicide screenings and case management are tailored to the resources of each site. A baseline will be established via survey in 2000 and repeated in 2001.

Data Source: Local annual survey and database linked with RPMS as appropriate.

Baseline: To be determined in FY 2001, survey was inconsistent in FY 2000.

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: These indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also directly supports several HP 2010 objectives in Focus Area 18: Mental Health and Mental Disorders which address the incidence of suicide.

Program Performance: No FY 1999 Indicator

Pilot Prevention Group:

The following three indicators represent demonstration efforts to test the application of prevention technologies in AI/AN communities and address community based cardiovascular disease prevention, childhood obesity control, and tobacco control. The successful strategies learned from these pilot projects will be then be diffused to other AI/AN setting in the future.

Indicator 28: During FY 2002, the IHS will continue collaboration with NIH to assist three AI/AN communities to implement culturally sensitive community-directed pilot cardiovascular disease prevention programs.

Rationale: The purpose of this indicator is to collaborate with NIH and AI/AN communities in the development of community-directed culturally sensitive prevention programs to address cardiovascular disease and serve as models for diffusion to other AI/AN communities.

Cardiovascular disease represents the single largest cause of death for AI/AN people above the age of 45. Furthermore, cardiovascular disease can be viewed as a complication of diabetes because of the much higher incidence of cardiovascular disease in diabetics. Within segments of the AI/AN population the prevalence of diabetes is the highest in the world while other segments with historically low diabetes rates are now experiencing dramatic increases. The diabetes death rate for AI/AN increased by almost 13 percent between the period of 1992-94 and 1994-96, and there is no evidence from any subgroup that the problem is lessening anywhere. A growing body of evidence supports that the approaches currently available to prevent the onset of heart disease and diabetes, and in some cases reverse their early stages, are the control of diet and exercise.

Over the past two years, the IHS has collaborated with the NIH National Heart, Lung, and Blood Institute and three AI/AN sites to assess their readiness to develop locally-directed cardiovascular disease prevention interventions that utilize community empowerment and other recognized models of behavioral change that can be tailored to be culturally appropriate.

Approach: The approach for this indicator is focused on collaborating to enhance long-term community commitment and capability in developing approaches to the prevention of cardiovascular disease at three AI/AN sites. This process will be mutually supported by IHS and NIH and will intentionally avoid a largely prescriptive approach from "outside experts" for program development but rather assist these communities in developing the capabilities internally to apply intervention technologies that are culturally tailored to these communities' social environment.

Clearly identifying approaches to the integration of diet control and exercise and fitness activities into the local culture can be best accomplished by the bringing together the knowledge of evidenced-based practices and theories (i.e., social learning theory, self-efficacy, etc.) with the knowledge of local culture, beliefs and practices. The FY 2001 target for this indicator is the collaborative development and community acceptance of the prevention plan. The FY 2002 target is the actual implementation of the each site's prevention program.

Potential interventions adopted are likely to vary considerably based on the tailoring process and support requested by sites but may include:

- organization-based fitness and diet control programs (worksites, churches)
- school-based fitness and diet control programs education programs for Head Start - high school and college
- social marketing of healthy practices through available media sources (radio, TV, newspapers, social events, the web)
- use of field public health staff to reach families in homes or other sites (e.g., public health nurses, health aides, health educators, dietitians and nutritionists)
- integration of traditional healing practices
- expanded clinic-based fitness and diet control intervention

While the evaluation must be linked to the nature of the interventions the potential levels of evaluation that are likely to be developed included:

Long term – death and disease rates

Intermediate – observed or reported changes in risk factors (behavioral changes)

Short term – observed or reported changes in knowledge or attitudes

Immediate – activity implementation and monitoring

Data Source: To be developed by local sites consistent with interventions

Baseline: No well-defined programs believed to be currently functioning

Type of Indicator: Impact and Balanced Scorecard: innovation and learning perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 1.3 *Improve the Diet and the Level of Physical Activity of Americans*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This objective is likely to support several HP 2010 objectives including many under section 12 (Cardiovascular Disease and Stroke), section 19 (Nutrition and Overweight), 5-7 (Diabetes: cardiovascular deaths), and Focus Area 22 (Physical Activity and Fitness)

Program Performance: No FY 1999 Indicator

Indicator 29: During FY 2002, maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites and evaluate community acceptance and participation in program interventions.

Rationale: This indicator is part of a long-term effort to identify effective interventions to prevent childhood obesity. Obesity is prevalent among AI/AN people of all ages and is increasing significantly in a growing number of communities. Obesity is an important risk factor for cardiovascular disease and diabetes, which are perhaps the greatest single health problems for the AI/AN population. Unfortunately, success in reducing the prevalence of obesity and diabetes on a population basis has not been consistently documented. Evidence supports that children who are obese beyond infancy are at risk for elevated circulating serum insulin, which may be a precursor to the development of type 2 diabetes later in life.

Infant nutrition is emerging as another important factor in childhood obesity. Recently published studies of Pima Indians and also of Bavarian children show that breastfeeding for at least two months is associated with a statistically significant protection from obesity in early childhood. It has also been demonstrated that obese older children are more likely to become obese adults. Fitness promotion and obesity prevention in childhood are expected to be more effective at preventing adult obesity and its complications, including type 2 diabetes, than weight reduction programs for adults.

It is the intent of this objective to pilot a series of at least five multidisciplinary/multidimensional community projects to address nutrition and fitness in early childhood. Ongoing periodic surveillance of school aged heights and weights will continue to monitor overweight prevalence in older children. Insights gained from the 6-year NIH-sponsored Pathways obesity prevention intervention in third, fourth, and fifth grade students, which began in FY 1997, will provide larger-scale interventions for school children. The recently released Surgeon General's Report on Physical Fitness outlines additional intervention strategies for reducing obesity. This objective directly supports the HP 2010 objectives addressing "Nutrition" and "Physical Activity and Fitness."

Approach: The responsible parties are the local I/T/U, Head Start, and WIC service sites. The IHS Area and USDA Regional offices can provide assistance in development and coordination of media campaigns. The IHS Office of Public Health is responsible for overall coordination of the effort. The linkages with the USDA-WIC program, the USDA, the DHHS Head Start Program, CDC Nutrition and Physical Activity Division, and the National Diabetes Prevention Center in Gallup, NM are critical. This objective is linked in part to Indicator 8, assurance of well child visits.

The strategies for success require effective multidisciplinary outreach and management of clinic and community programs, coordination of WIC, well child care, and education programs such as Head Start and Early Head Start. This activity is dependent upon parent education to assure they are aware of the importance of routine and periodic assessment of well children. Secondly, the effective identification of children in the intervention age groups is important. Public health nutrition, public health nursing, Community Health Representatives, WIC, Head Start programs,

and parent groups are important components in identifying children and families who are to benefit from this intervention.

Coordination of maternal and child health clinical care, community activities, and community involvement are also critical to prevent childhood obesity. Interventions will be piloted and evaluated initially at selected, interested demonstration sites, and then successful strategies and ideas will be disseminated to all programs. Evaluations of acceptance and participation must be tailored to each community and approved by health boards or other stakeholders groups. Clinical data will be collected through the IHS RPMS computerized health record system using the PCC BMI reports developed to measure prevalence of obesity in the clinic population. Coordination between the Pediatric Surveillance System managers at the CDC Nutrition and Physical Activity Division and the IHS Office of Public Health is critical for data access and analysis of the IHS Service Area data subset.

Data Source: CDC Pediatric Nutrition Surveillance System (PDNSS), IHS RPMS system, consumer surveys, focus groups, observational surveys, and rates of participation.

Baseline: Determined by FY 1999 indicator and reported below. Baseline for acceptance and participation will levels will be collected beginning in FY 2001 and continue in FY 2002.

Type of Indicator: Impact/Outcome and Balanced Scorecard: innovation and learning

Linkages: This indicator is part of a long-term effort to reduce childhood obesity and supports the the DHHS Strategic Plan, Strategic Objectives 1.3 *Improve the Diet and the Level of Physical Activity of Americans*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This objective also directly supports the HP 2010 objectives addressing Focus Area 22: Physical Activity and Fitness and Focus Area 19: Nutrition and Overweight and will require significant collaboration between IHS, CDC, WIC, and Head Start.

Program Performance: The FY 2000 indicator committed to developing at least five pilot sites to test multidisciplinary and multidimensional intervention strategies for reducing childhood obesity for Head Start population (3-5 year olds) and/or third grader children (8-10 year olds). This indicator was fully met in FY 2000 when five tribal Head Start programs were selected to pilot obesity prevention and intervention approaches in their respective communities. The IHS had collaborated with Head Start in developing a Head Start- IHS obesity prevention project entitled "Healthy Children, Healthy Families, Healthy Communities" that began in early 1999 with a "Future Search Conference" of stakeholders to begin planning the program with the broadest input. This program seeks to develop partnerships with AI/AN Head Start grantee programs, IHS and tribal health programs, and outside organizations.

The pilot sites selected from 18 applications are: Northern Cheyenne Head Start; Winnebago of Nebraska Head Start; Red Cliff Early Head Start and Head Start Program; Eastern Band of Cherokee Head Start; and San Felipe Pueblo Head Start. Each pilot site will tailor a multidisciplinary approach to test strategies to reduce the incidence of obesity with Head Start children (0-5 years old), their parents, Head Start staff and the tribal community at large. Each site is required to develop a community based project and strategic plan that includes an evaluation plan for ongoing monitoring of objectives and outcomes.

Current best practices and research are shared with the pilot sites through monthly conference calls, quarterly meetings and a web board. In addition, each site receives on site consultation to develop interventions and receives training and technical assistance at each quarterly meeting. Each pilot program will develop a tribal community plan that will include a nutrition, physical activity and behavioral health intervention. Specific activities and individual, family and community interventions are based on respective community need, health status and community assessments. For example, the Northern Cheyenne Head Start has engaged their local markets to allow staff to label healthy food in their store so tribal members are able to quickly identify healthy food choices for their families while shopping. This intervention was piloted in one store at the permission of the retailer. It was so popular, other vendors in the community requested assistance in establishing the same service.

Indicator 30: During FY 2002, five of the six tribal tobacco control organizations funded in FY2001 will accomplish all of the following:

- a. **train key personnel in tobacco control and prevention methods by IHS, CDC, and other appropriate organizations.**
- b. **develop capacity to provide assistance to Tribes in their region for tobacco policy development, including developing and sharing model tribal policies for control of Environmental Tobacco Smoke, Youth Access, and Advertising.**
- c. **initiate a process to assess tobacco use patterns among AI/AN youth in their region.**

Rationale: Data from the BRFSS show that AI/AN both smoke and chew tobacco more than any other racial or ethnic group in the US. This is reflected in high rates of cancer and heart disease in Alaska and the Northern Plains, where smoking rates are highest. Furthermore, there is evidence that in the Southwest, where Indian smoking rates have been low, youth are smoking in increasing numbers. Considerable evidence supports that health promotion efforts that entail lifestyle change are more effective if initiated and performed by culturally competent individuals and community-based organizations. By supporting these tribal organizations with Cooperative Agreements, we hope to establish a tobacco control infrastructure that will be responsive to local needs and beliefs. IHS and CDC are collaborating to support these new tobacco control centers.

Approach: IHS Cancer Prevention and Control Program and CDC/Office on Smoking and Health will work together to provide technical assistance and training to the funded centers to ensure that they are able to perform the stated tasks.

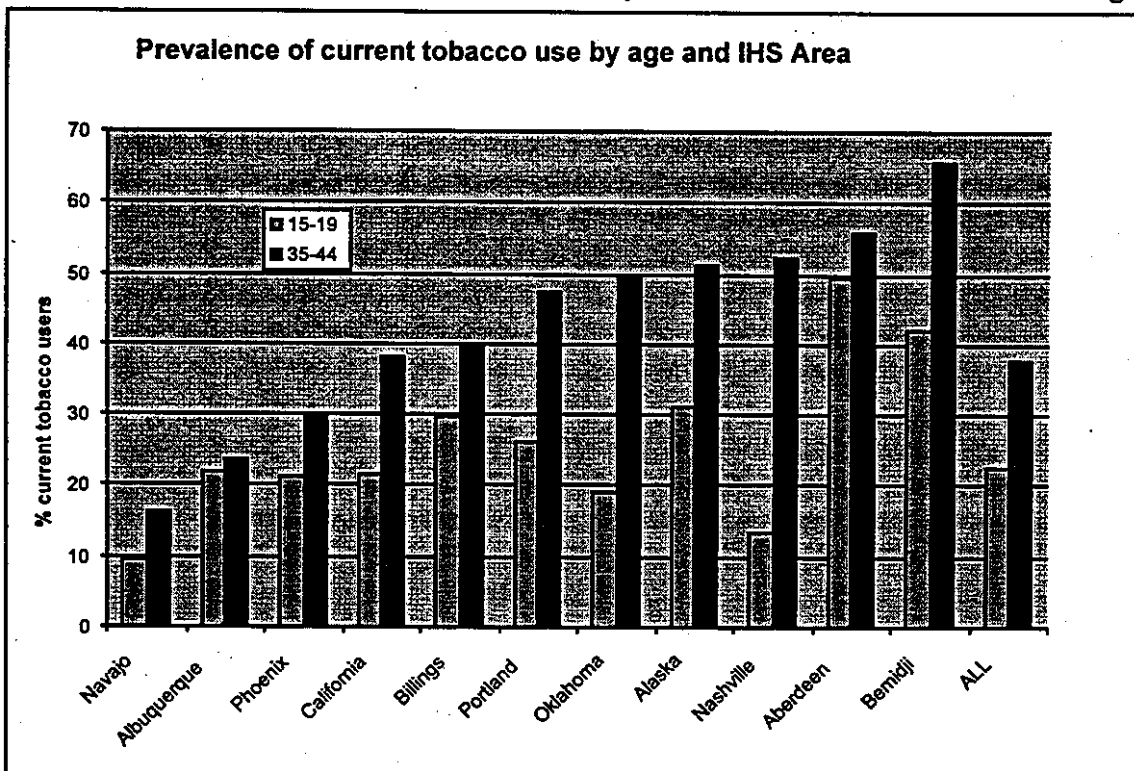
Data Source: Biannual reports submitted by the funded centers.

Baseline: Three of the six funded centers have been active in tobacco control for several years, but in a more limited scope. Those three have some trained staff; the new centers do not. Only one center has been active in Tribal tobacco policy in the past. Two centers have been active in assessment of youth smoking patterns.

Type of Indicator: Impact and Balanced Scorecard: innovation and learning

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 1.1 Reduce Tobacco Use, Especially among Youth; 3.6 Improve the Health Status of American Indians and Alaska Natives, and 5.1 Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population. It is supported by an IHS/CDC Agreement, and supports several HP 2010 objectives in Focus Area 27: Tobacco Use.

Program Performance: The FY 2000 tobacco indicator was to determine IHS Area and age-specific prevalence rates for the usage of tobacco products. In FY 2000, 22.6% of all 15-19 year olds and 37.8% of all 35-44 year olds identified themselves as current tobacco users (either smoking or smokeless). This was determined through the IHS Oral Health Survey, a questionnaire administered by dentists throughout the IHS system. There were over 2000 respondents in each age category. Breakdown by IHS Areas is shown in the following chart:



Adult Area tobacco use rates varied from 16.3% in Navajo Area to 65.6% in Bemidji Area. Youth tobacco use ranged from 9.5% to 49.4%. This is consistent with previously reported data that show low tobacco use rates in the Southwest and very high rates in the Northern Plains and Alaska.

An effective tobacco control strategy must include both clinical cessation programs and community-based prevention. At this time, the IHS Areas are attempting to identify existing resources to support the necessary staff and pharmaceuticals for such efforts. However, we are developing a network of community prevention programs in partnership with CDC Office on Smoking and Health.

HIV/AIDS Group:

The following two indicators address improving surveillance of HIV/AIDS and the implementation of risk reduction counseling with the long-term goal of reducing the spread of HIV infection in the AI/AN population.

Indicator 31: During FY 2002, maintain ongoing surveillance of HIV/AIDS and establish baselines for completeness of reporting in at least 6 additional Areas.

Rationale: The purpose of this indicator is to assure that accurate and complete data on the burden of HIV infection and AIDS among American Indians and Alaska Natives and are critically needed to plan for resource mobilization and allocation, and to guide and evaluate intervention programs to prevent HIV transmission. The Indian Health Service maintains service data that include HIV and AIDS diagnoses, and providers submit this information to the HIV/AIDS surveillance programs of the appropriate State Health Departments, from which they are then sent to CDC. A cumulative total of 742 HIV infections and 2,132 AIDS cases among AI/ANs had been reported to CDC as of December 31, 1999 (CDC. HIV/AIDS Surveillance Report, 1997 Year-End Edition, Vol. 9, No.2). Reported AIDS cases among AI/AN have increased 10% per year from 1997 to 1999 (CDC. HIV/AIDS Surveillance Report, 1999 Year-End Edition, Vol. 11, No.2).

Data analyzed for FY 2000 indicated that incompleteness of case reporting and misclassification of race/ethnicity contributed to underestimation of the burden of HIV and AIDS in AI/AN communities. Because FY 2000 data were found to not accurately describe the HIV/AIDS epidemic among American Indians and Alaska Natives, the FY 2001 indicator has been revised to reflect the need to increase the completeness of case reporting (see change table, Indicator 31 on page 130). The FY 2002 version is designed to measure the increasing ability to accurately track HIV/AIDS spread within the AI/AN population.

Approach: Completeness of surveillance data is to be evaluated by matching IHS RPMS data with HIV/AIDS surveillance data collected by State Health Departments/CDC. With adherence to standards for protection of confidentiality, records of persons diagnosed with HIV or AIDS will be abstracted from the RPMS data system and sent to the appropriate State Health Department for matching with the HIV/AIDS data system, to determine whether the cases have been reported.

Data Source: IHS RPMS; State and CDC HIV/AIDS Surveillance Systems

Baseline: To be determined in FY 2001

Type of Indicator: Process and Balanced Scorecard: innovation and learning

Linkages: This indicator is changed from FY 2001 and supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. It is supported by IHS/CDC agreements, and supports several HP 2010 "HIV Infection" and "Surveillance and Data" objectives.

Program Performance: The FY 2000 performance indicator committed to determine prevalence rates of HIV/AIDS infection in American Indian/Alaska Natives at Indian Health Service treatment facilities and obtain infection rate nationally from Centers for Disease Control. This measure was partially met. Prevalence rates of HIV/AIDS infection in American Indian/Alaska Natives at Indian Health Service treatment facilities were not obtainable given the existing data infrastructure, as laboratory codes for HIV testing and testing HIV positive have not yet been standardized. To address this, a procedure is being developed for extraction of data

from key IHS Resource Patient Management System data files and mapping to a standard set of codes, so that data aggregation is possible in the future. However, until a generalizable procedure is developed, this project is proceeding on a facility-by-facility basis (as each facility has some codes that are unique).

The Centers for Disease Control and Prevention reported an AIDS rate of 9.7 per 100,000 for American Indians and Alaska Natives for the year 2000. However, some preliminary investigation has indicated that there may be substantial underreporting because many American Indians/Alaska Natives are listed as being of another race in the surveillance data. To address this issue, several projects are underway to quantify the degree of misclassification by race. It may be possible to use the results from these projects to apply a racial misclassification correction factor to these surveillance data.

Note, this is a new FY 2002 and FY 2001 Indicator

Indicator 32: During FY 2002, increase the percentage of high risk sexually active persons who have been tested for HIV and received risk reduction counseling at least 10% above the baseline established in FY 2001.

Indicator 32: During FY 2001, obtain a baseline measure of the percentage of high-risk sexually active persons who have been tested for HIV and received risk reduction counseling, from a sample of IHS facilities.

Rationale: The purpose of this indicator is to reduce the spread of HIV infection in AI/AN communities. The benefits of early knowledge of HIV serostatus are greater now than at any time during the epidemic. For HIV-infected persons, highly active antiretroviral therapy has improved dramatically the quality and duration of life and may reduce the risk for transmission by decreasing viral load (Palella FJ, Delaney KM, Moorman AC. Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. *N Engl J Med* 1998;338:853--60; Gupta P, Mellors J, Kingsley L, et al. High viral load in semen of human immunodeficiency virus type 1 infected men at all stages of disease and its reduction by therapy with protease and nonnucleoside reverse transcriptase inhibitors. *J Virol* 1997;71:6271--5; Vernazza PL, Gilliam BL, Flepp M, et al. Effect of antiviral treatment on shedding of HIV-1 in semen. *AIDS* 1997;11:1249--54.). Reduced HIV transmission also can occur because many infected persons may reduce sexual risk behavior after HIV-infection diagnosis (Denning P, Nakashima A, Wortley P, the SHAS Project Group. High-risk sexual behaviors among HIV-infected adolescents and young adults [Abstract]. In: Program and Abstracts of the 6th Conference on Retroviruses and Opportunistic Infections. Chicago, Illinois: Foundation for Retrovirology and Human Health, 1999.). In addition, monitoring the burden of HIV/AIDS among American Indians and Alaska Natives depends ultimately on the diagnosis of infections through testing of high-risk individuals. Therefore, to support prevention efforts and to improve monitoring of the spread of HIV/AIDS, the Indian Health Service is working to increase availability and access to voluntary and confidential HIV diagnostic testing by constituents who do not know their HIV status, link them to care and prevention services, and assist them in adhering to treatment regimens and in sustaining risk reduction behavior. The percentage of high-risk persons who have received an HIV test is thus a critical indicator, and was added as a new indicator for FY 2001 to establish a baseline with the FY 2002 version designed to measure the expansion of HIV testing and counseling.

Approach: A baseline will be established in FY 2001 through implementation of a web-based surveillance enhancement software in selected IHS facilities. This software will query the RPMS system to determine the percentage of STD patients tested for HIV in IHS facilities. The web-based system will be used again in FY 2002 and the results compared with the FY 2001 baseline measure.

Data Source: ID Web, a web-based surveillance enhancement software.

Baseline: To be determined in FY 2001

Type of Indicator: Impact/Outcome and Balanced Scorecard: innovation and learning

Linkages: This indicator is changed from FY 2001 and supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. It is supported by IHS/CDC agreements, and supports several HP 2000 "HIV Infection" and "Surveillance and Data" objectives.

Program Performance: No FY 2000 indicator

Environmental Surveillance Indicator:

Indicator 33: During FY 2002, the IHS will increase the proportion of American Indian and Alaska Native communities assessed by the environmental health surveillance system by 10% over the FY 2001 level.

Rationale: This indicator is directed at reducing environment threats to health by expanding community information for decision making. Community environmental health status has traditionally been determined by completing environmental health surveys of individual facilities listed on the Facility Data System (FDS) inventory. However the overall environmental health status of a community is more than a simple sum of inter-related parts. An accurate determination of a community's environmental health status must be based on a comprehensive analysis of how those parts collectively affect the overall environmental health and quality of life of the residents of the community. Overall community environmental health status will be continuously assessed through the use of the environmental health surveillance system that will be developed during FY 2000. However to effectively measure improvement in the environmental health status of a community, baseline environmental health status must be determined by conducting initial comprehensive community environmental health assessments.

Approach: The Environmental Health Services program will work with the National Center for Environmental Health (NCEH), the National Association of City and County Health Officials (NACCHO), and Tribal partners to establish a surveillance protocol and implementation during FY 2000. This protocol will be employed in conducting the initial community assessment and for ongoing surveillance. At the regional level, this project will be coordinated with the IHS Area Environmental Health Officers in partnership with the tribes and local IHS environmental health services programs.

The collection, organization, and implementation of environmental health and epidemiological data may redesign the services and activities currently provided by and recommended by the

Environmental Health Services program. We are not certain that the assumptions used to build the current system are still valid (FDS vs. risk-based decision making). Data analysis is necessary to establish baseline levels of community environmental health, evaluate the effectiveness of existing programs and to plan future programs to insure that resources and activities are best targeted to most effectively reduce environmentally related disease and injury at the local level.

Data Source: IHS Environmental Health Surveillance System developed in FY 2000.

Baseline: To be established by the end of FY 2001.

Type of Indicator: Process and Balanced Scorecard: internal perspective

Linkages: This indicator is an extension of FY 2000 Indicator 26. It supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population*. It also broadly supports many of the HP 2010 objectives in Focus Area 8: Environmental Health.

Program Performance: For FY 2000 this indicator committed to developing the protocol and implementation plan for an environmental health surveillance system to provide the information needed to identify environmental health issues, establish local and regional priorities, and develop and evaluate environmental interventions and programs. This indicator was partially met during FY 2000 with the following actions being completed:

- An IHS/Tribal Community Assessment Workgroup was established. The Workgroup held one conference call to discuss the goals of the community assessment process and organize itself to work toward achieving those goals.
- Consultation meetings were held in Denver and Albuquerque to solicit input from tribal and community leaders regarding their perspective of community environmental health needs.
- IHS received input from the National Center for Environmental Health and the National Association of City and County Health Officials regarding existing community assessment protocols that were forwarded to the Community Assessment Workgroup.
- Draft protocols were field tested in tribal communities in the Bemidji, Phoenix, and Tucson Areas.

The following factors were responsible for the Agency's failure to completely meet this indicator:

- The responsibilities for coordinating activities under this indicator were assigned to the Deputy Director, Division of Environmental Health Services (DEHS). This individual transferred out of the Agency in November of 1999 and was not replaced until November of 2000. At the same time, one additional senior staff member was detailed to the Office of Public Health and not replaced until November of 2000. As a result of these temporary staff reductions there simply wasn't enough staff time available to complete the identified activities.
- The process of soliciting input from tribal and community leaders proved to be more time consuming than originally estimated.

Recent additions to the DEHS will relieve the staffing shortages that were experienced during FY 2000, and we are confident that the protocol will be completed and field implementation begin during this fiscal year.

2.2.1 Capital Programming/Infrastructure Category: Program Description, Context and Summary of Performance

Program Description and Context

Capital Programming/Infrastructure indicators represent the physical infrastructure that contributes to a healthy environment by assuring safe water and sewage facilities, medical facilities where health services can be adequately provided, and the ability to maintain the medical facilities that are critical to our mission.

Sanitation Facilities Construction – supports the construction of water, sewage, and solid waste systems (see page IHF-17 in FY 2002 budget document).

Health Care Facilities Construction – supports the construction of new or replacement health care facilities (see page IHF-23 in FY 2002 budget document).

Maintenance and Improvement – supports ongoing health care facility maintenance, alteration, and repair (see page IHF-11 in FY 2002 budget document).

2.2.2 Capital Programming /Infrastructure: Performance Indicators

These indicators were selected and based on the following criteria:

- supports components of the Indian Health Facilities Appropriation and funding priorities of I/T/Us identified in the budget formulation process
- are supported by existing data systems that record the need for physical infrastructure or improvements to the existing infrastructure
- follows the formula-based prioritization of each project's relative need
- has demonstrable link to improved access to health services or healthier living environments

The data that support these indicators are recorded at the local level where projects are conceptualized based in strict protocols and formulas. These data are compiled at the Area and Headquarters level and reviewed for accuracy and then compare against similar projects. The validation and verification of this information is essential to the facilities programs since it is used to distribute resources as well as measure performance. The link between funding levels and our ability to accomplish these indicators is relatively direct and supported by well-quantified and validated planning formulas.

These indicators support many of the Departmental and IHS areas of focus by providing a foundation where health services can be effectively delivered and objectives reached. Without a healthy living environment, access to safe medical facilities, and proper maintenance most of the objectives could not be met.

**Performance Summary Table 3:
Capital Programming/Infrastructure**

Performance Indicator	FY Targets	Actual Performance	Reference
Capital Programming/Infrastructure Group			
Indicator 34: Address the net backlog of essential maintenance, improvement, and renovation (BEMAR) needs for health care facilities.	FY 02: to be determined FY 01: address \$12 million of FY 2000 BEMAR FY 00: address \$12 million of FY 1999 BEMAR FY 99: maintain backlog at \$243 million	FY 02: FY 01: FY 00: \$12 million addressed FY 99: backlog maintained at \$243 based on FY 1997 formula FY 98: \$243 million baseline	P: p. 103 B: p. IHF-11
Indicator 35: Provide sanitation facilities to new or like-new homes and existing Indian homes.	FY 02: 2,528 New/L. New <u>12,727 Existing</u> Total 15,255 FY 01: 3,800 New/L. New <u>10,930 Existing*</u> Total 14,730 FY 00: 3,740 New/L. New <u>11,035 Existing</u> Total 14,775 FY 99: 5,900 New/L. New <u>9,330 Existing</u> Total 15,230	FY 02: FY 01: FY 00: 3,886 New/L. New <u>14,490 Existing</u> Total 18,376 FY 99: 3,557 New/L. New <u>13,014 Existing</u> Total 16,571	P: p. 104 B: p. IHF-17 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 36: Improve access to health care by construction of the approved new health care facilities.	FY 02: complete scheduled phase of construction of appropriated facilities FY 01: complete scheduled phase of construction of appropriated facilities* FY 00: complete scheduled phase of construction of appropriated facilities FY 99: complete scheduled phase of construction of appropriated facilities	FY 02: FY 01: FY 00: 5 of 6 projects completed on schedule FY 99: all projects completed on schedule	P: p. 105 B: p. IHF-23 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Total Capital Programming/Infrastructure Funding:	FY 02: \$357,034,000** FY 01: \$322,377,000 FY 00: \$277,303,000 FY 99: \$255,953,000 FY 98: \$221,009,000 ** includes 15% of M/M and PI Collections and Quarters Collections		P: page # in perform. plan B: page # in budget justif.

FY 2002 Indicators

Capital Programming /Infrastructure Group:

Indicator 34: *The FY 2002 indicator is being revised to more directly measure these performance parameters and will be included in the initial FY 2003 submission in September 2001.*

Indicator 34: During FY 2001, the IHS will reduce \$12 million of the FY 2000 Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) for health care facilities.

Rationale: This indicator directly addresses both quality and access to critical health care services for AI/AN people. The provision of quality health care services requires effective and efficient space, including reliable supporting building systems (housing for staff, maintenance shops, etc). This indicator represents a commitment to this activity that is also fundamental to maintaining hospital and clinic accreditation (see Indicator 20 on accreditation on page 78).

Approach: This indicator is part of an IHS effort to more accurately determine the resources and processes required to sustain physical surroundings that enhance the delivery of health care services. This includes maintaining both IHS and tribal health care facilities in good working order, eliminating environmental and safety hazards, and modifying space as needed to facilitate changing service delivery practices. To achieve this indicator, the IHS will complete an evaluation of the current listing of the BEMAR and initiate major maintenance and improvement projects that will result in the gross reduction to the 2001 BEMAR. Thus, the target level and actual performance will be compared with the baseline BEMAR at the time the target was selected.

The physical condition of IHS-operated, federally-owned and tribally owned health care facilities is evaluated continuously by local facility personnel and through annual general surveys conducted by local facility personnel and IHS Area Office engineers. In addition, comprehensive "Deep Look" surveys are conducted every five years by a team of specialists, which may include IHS and tribal engineers, architects, and operations experts, and occasionally technical specialists from private sector architectural/engineering firms.

A major facet of this activity is an improvement of the data system in which identified facilities deficiencies are listed. The revised system has moved input and querying of data to a lower level, Area Office and/or field sites, so the information may be used to support and improve decision making at those levels and the capturing of expenditures for capital improvements for buildings, as promulgated by the Federal Accounting Standards Advisory Board will be enhanced.

Data Source: Identified deficiencies recorded in the Facilities Engineering Data System.

Baseline: The 2000 backlog of identified deficiencies totaling \$446 million. The FY 2001 backlog of identified deficiencies will be provided in January 2001.

Type of Indicator: Process/Impact and Balance Scorecard: internal perspective

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and generally, many of the HP 2010 objectives.

Program Performance: The FY 2000 performance measure was to address \$12 million of the FY 2000 Backlog of Essential Maintenance, Alterations, and Repair (BEMAR) for health care facilities. The FY 2000 BEMAR was reported as \$446 million; the FY 2001 BEMER is reported as \$442 million. During FY 2000, an estimated \$12 million in M&I funds were allocated to projects that would reduce the BEMAR, meeting the FY 2000 goal. With the known additions to the BEMAR during FY 2000, a net reduction of \$4 million was accomplished.

In FY 2000 the Facilities Database System began the process of separately logging additions and completed tasks. Since new tasks are continually added into the database, this logging will enable IHS to separate out the specific value of tasks added and completed. Until this process is fully operational, only the net change to the total database can be determined.

Indicator 35: During FY 2002, provide sanitation facilities projects to 15,255 Indian homes (estimated 2,528 new or like-new homes and 12,727 existing homes) with water, sewage disposal, and/or solid waste facilities.

Rationale: This indicator directly supports improved environmental health for AI/AN people. The IHS Sanitation Facilities Construction Program, an integral component of the IHS disease prevention activity, has carried out those authorities since 1960 using funds appropriated for Sanitation Facilities Construction to provide potable water and waste disposal facilities for American Indian and Alaska Native (AI/AN) people. As a result, the rates for infant mortality, gastroenteritis morbidity, and other environmentally related diseases have been dramatically reduced, as much as 80 percent since 1973. Compelling evidence supports that many of these health status improvements are attributable to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. Satisfactory environmental conditions (e.g., safe piped water and adequate sewage disposal) place fewer demands on IHS' primary health care delivery system. However, AI/AN homes are still seven times more likely to be without clean water than homes in the broader U.S. with most of these homes located in geographically isolated areas, particularly Alaska and the Navajo Reservation.

Approach: This program regularly updates the needs for sanitation facilities based on the Indian Health Care Improvement Amendments (Title II, Section 302(g) 1 and 2 of P.L. 100-713). From these process, a backlog of needed sanitation facilities to serve existing homes is identified and updated annually. Based on the end-of-year FY 2002 estimates, the cost of technically and economically feasible projects to correct these needs for existing homes was \$831 million out of a total need of \$1.781 billion. It is considered feasible to provide sanitation facilities for between 95 and 98 percent of all existing Indian homes. Maximum health benefits will be realized by addressing needs identified and providing facilities for new/like new homes when they are constructed.

Data Source: The Sanitation Facilities Deficiency System.

Baseline: Not Applicable

Type of Indicator: Impact and Balance Scorecard: internal perspective

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and several of the HP 2010 objectives in Focus Area 8: Environmental Health.

Program Performance: The FY 2000 performance measure was to provide sanitation facilities to 3,740 new and like-new homes and 11,035 existing homes by the end of FY 2000. In FY 2000 the IHS provided sanitation facilities to 3,886 new and like-new homes and 14,490 existing homes for a total of 18,376. These exceeded the total goal of providing sanitation facilities for 14,775 homes. This significant increase in existing homes was the result of more projects to upgrade existing community sanitation facilities infrastructure.

Indicator 36: During FY 2002, assure the timely phased construction of the following health care facilities:

Hospitals:

Ft. Defiance, AZ-construction

Winnebago, NE- construction

Rationale: This indicator supports the replacement health care facilities to increase access to personal medical services supported by the IHS. These medical services can be compared to medical services available to the general population (appointments to see primary care physicians, nurses, dentists, etc.). Efficient space for health care delivery allows for more appointments and for patients to see more health care providers in one trip. People are also reluctant to use old run-down facilities but are more likely to seek needed health care when provided in modern facilities. Although accessible is synonymous in this usage with obtainable health care services IHS can demonstrate that workloads have increased or more comprehensive services are provided. Two examples are the Shiprock Hospital (inpatient facility) in New Mexico where the planned workload in 1995 for this facility was 101,572 and in 1999 the workload was 117,764; Wagner Health Center (outpatient facility) in South Dakota where the planned workload in 1991 for this facility was 16,656 and in 1999 the workload was 19,551. In the examples given, the measure of access is overall workload while the types of health services are offered may be as important as the overall availability of health services, depending on the circumstances. These issues are addressed individually in the Program Justification Documents for each planned facility.

Likewise, modern facilities help recruit and retain health care providers that can result in improved access and continuity of health care. Once a replacement facility has been completed and fully staffed, IHS has experienced an average increase in patient visits of approximately 60% over the old facility. The planning and designing of additional facilities is the first step in improving access for identified locations.

Approach: The IHS developed the Health Facilities Construction Priority System (HFCPS) methodology in response to congressional directive to identify planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority outpatient care facilities and to submit those needs through the President to the Congress. Under the three-phase HFCPS process, the IHS Headquarters solicits proposals for facility construction

from the Area Offices and ranks them according to their relative need for construction. Factors used to determine relative need are workload, age, isolation or alternatives to construction, and existing space data. The highest-ranking proposals are added to the Priority Lists.

When new projects are to be added to the Priority Lists, IHS Headquarters asks each IHS Area Office to submit proposals for Phase I consideration. The IHS uses the HFCPS methodology to review these proposals and to determine which will be considered during the more intensive Phase II review. A limited number of proposals that successfully complete Phase I are considered further during Phase II. The IHS examines these proposals in greater detail and applies the methodology to determine those proposals that will be considered during Phase III.

During Phase III, appropriate IHS Area Offices prepare a Program Justification Document (PJD) for each proposed project still being considered. IHS Headquarters reviews each PJD. If the PJD justifies construction, it is approved and the project is placed on the appropriate priority list below those already on the list. Proposed projects that have been approved and placed on a priority list remain on the list until they have been fully funded by congressional appropriations or other funding mechanism.

After projects are placed on the Priority Lists, IHS updates its 5-year planned construction budget. That budget is updated yearly and used as the basis for funding requests. The HFCPS is generally applied using existing IHS resources (staff and equipment); however, some Area Offices have procured assistance in developing the PJD and POR.

Data Source: Health Care Facilities Priority System and Health Care Facilities Planned Construction Budget (5-Year Plan).

Baseline: Not Applicable, the IHS Inpatient and Outpatient Facilities Priority List is used to determine needed construction priorities.

Type of Indicator: Process/Impact and Balance Scorecard: internal perspective

Linkages: These indicators supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services* and generally, many of the HP 2010 objectives in Focus Area 1: Access to Quality Health Services.

Program Performance: The FY 2000 indicator committed to continuing construction of the replacement hospital in Fort Defiance, Arizona; starting construction of the replacement hospital in Winnebago, Nebraska; continuing construction of the replacement health center in Parker, Arizona; designing the new health center in Red Mesa, Arizona; designing and starting construction of the staff quarters to support the hospital in Zuni, New Mexico; and continuing the design and construction of dental units. These targets were accomplished as follows:

Replacement Hospital in Fort Defiance, Arizona: Using the fiscal year (FY) 2000 appropriation, construction continued for the replacement hospital portion of the project. The FY 2000 GPRA goal was met.

Replacement Hospital in Winnebago, Nebraska: Using the FY 2000 appropriation, construction started for the replacement hospital. The FY 2000 GPRA goal was met.

Replacement Health Center in Parker, Arizona: Using the FY 2000 appropriation, the tribe continued construction of the replacement health center. The FY 2000 GPRA goal was met.

New Health Center in Red Mesa, Arizona: Using the FY 2000 appropriation, design of this project was started. The FY 2000 GPRA goal was met.

Additional Staff Quarters to Support Hospital in Zuni, New Mexico: The FY 2000 appropriation provided advance funding for this project. Pursuant to The Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, the Tribe was afforded the opportunity to do the project. Initially, the Tribe did not elect to do the entire project under P.L. 93-638. Now, the Tribe desires to do the entire project. The negotiation of the P.L. 93-638 construction contract is pending the Tribes completion of site selection process and planning documents. Funds will be transferred to the Tribe for design and construction after the P.L. 93-638 construction contract has been negotiated. Tribal leadership changes are delaying the development of a time schedule to complete the actions that will allow funds to be transferred to the Tribe. The FY 2000 GPRA goal was not met.

Additional Dental Units: Continuing this program, three additional projects were funded for design and construction, using the FY 2000 appropriation. The FY 2000 GPRA goal was met.

2.3.1 Partnerships, Consultation, Core Functions, and Advocacy Category: Program Description, Context and Summary Performance

Program Description and Context

The Partnerships, Consultation, Core Functions, and Advocacy aggregation encompasses the IHS' administrative and management functions, relationships with stakeholders and consumers, and strategies for collaboration in pursuit of the IHS mission. Data for these indicators come from recognized sources including budget reports and audits, a HHS survey, and a survey of the universe of stakeholders using recognized social survey methods. The two components of this aggregation are:

Partnerships, Consultation, Core Functions, and Advocacy Category Aggregation

Direct Operations - supports management and administrative functions for Area and Headquarters staff including policy development, budget formulation, health program support, and accountability requirements (see page IHS-109 in FY 2002 budget document).

Facilities and Environmental Health Support - provides administrative and management support for the construction, maintenance, and operation of health care facilities, staff housing, and sanitation facilities (see page IHF-31 in FY 2002 budget document).

2.3.2 Partnerships, Consultation, Core Functions, and Advocacy Category: Performance Indicators

The choice of indicators for this aggregation category are based on the following criteria:

- supports and encourages tribal sovereignty, the government to government relationship between tribes and the Federal government, and tribal self-determination
- supports and encourages collaboration with stakeholders, agencies, and organizations directed toward improving the health of AI/AN people
- supports and encourages sound management practices

Achieving these performance indicators, as well as the overall coordination of the GPRA and other Federal accountability requirements represent a significant challenge for the IHS and its reduce management and public health infrastructure. The reorganization of Headquarters and many Area offices has resulted in flatter organizational structures, less specialization in function, and greater use of self-directed teams in order to increase efficiency. However, it has become increasingly clear that coupled with improved data management capacity, there are two functions that must be supported to assure overall program success and these are:

- assuring that continued and expanded opportunities for tribal consultation and participation in IHS endeavors is supported
- assuring effective recruitment of needed health discipline is achieved and that orientation, training, and support are available to enhance the retention these staff.

FY 1999 Performance Summary Table 4:
Consultation, Partnerships, Core Functions, and Advocacy Indicators

Performance Indicator	FY Targets	Actual Performance	Reference
Consultation Improvement Indicator			
Indicator 37: Improve the level of I/T/U satisfaction with the processes for consultation and participation provided by the IHS, as measured by a survey of I/T/Us.	FY 02: secure OMB clearance for instrument and baseline FY 01: implement policy and submit instrument* FY 00: revise policy and instrument FY 99: establish policy and collect baseline	FY 02: FY 01: FY 00: revised policy proposed and instrument developed FY 99: policy established but baseline delayed	P: p. 111 B: p. IHS-109 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Administrative Efficiency and Effectiveness Group			
Indicator 38: Improve the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements at the IHS-wide reporting level.	FY 02: 82% FY 01: 79%* FY 00: no indicator FY 99: no indicator	FY 02: FY 01: FY 00: FY 99: NA FY 97: 74% baseline	P: p. 112 B: p. IHS-109 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 39: Maintain administrative infrastructure (Area and Headquarters) no higher than FY 1999 target level while maintaining full compliance with major Federal requirements (i.e., GPRA, GMRA, ITMRA, etc.).	FY 02: no indicator FY 01: no indicator* FY 00: 1876 FTE or less FY 99: at least 10% under FY 97 level or 1876 FTE	FY 01: FY 00: 1,569 FTE FY 99: -22% (1,619 FTE) FY 97: 2085 FTE baseline	P: p. 113 B: p. IHS-109 p. IHF-31 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 40: Increase the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators.	FY 02: no indicator FY 01: no indicator* FY 00: 19 or more addressing indicators FY 99: increase by 10% over FY 97 or 73 agreements	FY 00: 23 addressing indicators. FY 99: 86 total agreements and 18 address indicator FY 97: 66 agreements baseline	P: p. 115 B: p. IHS-109 p. IHF-31 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 41: Continue implementation of Managerial Cost Accounting systems across IHS settings.	FY 02: expand IT capability FY 01: secure IT capability FY 00: contin. implem. & develop pilot sites FY 99: begin implementation	FY 02: FY 01: FY 00: implem. contin. but pilots sites not developed FY 99: "cost centers" implemented in FY 1999	P: p. 116 B: p. IHS-109

Performance Indicator	FY Targets	Actual Performance	Reference
Quality of Work Life Indicator			
Indicator 42: The IHS will improve its overall Human Resource Management (HRM) Index score as measured by the DHHS annual HRM survey.	FY 02: at least 98 points FY 01: at least 97 points* FY 00: at least 94 points FY 99: no indicator	FY 02: FY 01: FY 00: 96 points FY 99: 93 points FY 98: 93 points baseline FY 97: 92 points	P: p. 117 B: p. IHS-109 p. IHF-31 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 43: Support the Tribal Self-Determination through technical assistance and application of the IHS Contract Support Cost Policy.	Technical Assistance FY 02: 100% of new tribes FY 01: develop protocol Contract Support Cost Review FY 02: 100% of new tribes FY 01: develop protocol FY 00: no indicator FY 99: no indicator	FY 02: FY 01: FY 02: FY 01:	P: p. 118 B: p. IHS-109 p. IHF-31
Total Consultation, Partnerships, Core Functions, and Advocacy Funding:	FY 02: \$89,282,000 FY 01: \$75,823,000 FY 00: \$72,884,000 FY 99: \$69,729,000 FY 98: \$67,038,000		P: page # in perform. plan B: page # in budget justif.

FY 2002 Partnerships, Consultation, Core Functions, and Advocacy Indicators

Consultation Improvement Indicator:

Indicator 37: During FY 2002, the IHS will collect baseline data to assess I/T/U stakeholder satisfaction with the revised consultation process developed in FY 2001.

Rationale: The purpose of this indicator is to improve the consultation process with IHS stakeholders. It is fundamental to the realization of the IHS Mission and Goal that I/T/Us increasingly become participating partners in the important processes that will guide the Agency into the next century. Given the number and diversity of I/T/Us, formal policies are essential to assure broad input, a rational and equitable approach to making timely decisions, and the highest possible buy-in across I/T/Us. Equally important is securing the data to assess how well the processes are actually working, and then improving them. In addition, this indicator serves as a proxy measure of the effectiveness of the IHS Tribal Management program. Finally, during the initial reorganization of the IHS in 1995-96, the IHS was encouraged by its stakeholders to assure opportunities for local I/T/Us to evaluate the agency's progress in enhancing the consultation process and supporting recommended changes.

Approach: It is critical that the IHS form a strong and effective partnership with its I/T/U constituents in addressing the health disparities. This partnership is essential to ensure that resources are effectively and efficiently utilized to maximize the positive impact health programs have on the target I/T/U populations. Partnerships already exist with such tribal entities as the National Indian Health Board (NIHB), Regional Indian Health Boards, the Tribal Self-Governance Advisory Committee (TSGAC) and the National Congress of American Indians (NCAI).

The starting point for this activity was with the development and implementation of the IHS consultation policy and was to be followed by the development of a survey instrument to assess I/T/U satisfaction with the consultation process. This policy was actually developed ahead of schedule and was in effect at the start of FY 1999. In addition, a survey instrument was developed and tested in the spring of FY 1999. This survey instrument was to be used in FY 1999 to establish a baseline and was to be accomplished by several tribal and AI/AN organizations. However, concerns about the how the consultation process was being implemented refocused the attention of the I/T/U stakeholders on revising the policy to address specific consultation processes and new and anticipated legislative changes. As a result the collection of data was delayed pending the revision of the policy by a team that includes the I/T/U stakeholders.

The IHS elected to honor our stakeholders' preferences and support the revision of the consultation policy/process during FY 2000. However, the process of attempting to integrate the variety of strategies for revising the existing consultation policy proposed by stakeholder groups resulted in a delay in the overall process. It is now anticipated that for FY 2001, the IHS will implement a revised policy and prepare a revised instrument for clearance as required by the Paperwork Reduction Act. For FY 2002 it is anticipated that this clearance will be completed and a baseline score will be compiled.

Data Source: I/T/U survey instrument and protocol

Baseline: From baseline survey completed in FY 1999.

Type of Indicator: Process

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.3 *Increase Consumer's Understanding of their Health Care Options*. It also underpins the IHS' commitment supporting the Self-Determination process and AI/AN community empowerment.

Program Performance: The FY 2000 performance indicator stated that the IHS would work with I/T/U stakeholders to revise the consultation process and develop an appropriate survey instrument and protocol to assess I/T/U satisfaction with the IHS consultation process. The IHS met this indicator in the following manner. During fiscal year 2000, discussions with I/T/U stakeholders on the effectiveness of the consultation process occurred at several national meetings of tribal leaders as well as numerous inter-tribal regional meetings. Discussions culminated in a December 28, 2000 letter to all "Tribal Leaders" and others from the Director, IHS. The letter attached the current IHS policy and a revised policy for the IHS that had been proposed for implementation by the Tribal Self-Governance Advisory Committee. Comments on the policies are being solicited from Tribal Leaders, urban Indian health leaders, and others. It is likely that based on the comments received, and further consultation that must occur before policy changes are made, that the IHS will implement a revised consultation process and policy in FY 2001. A survey instrument has been developed that will measure the "satisfaction" with any new consultation process and policy that is implemented in FY 2001. Activities are underway at present to obtain any clearances necessary before the survey is implemented.

Administrative Efficiency and Effectiveness Group:

This group of indicators addresses the improvement of administrative functions that support the improvement of health care efficiency and effectiveness.

Indicator 38: During the FY 2002 reporting period, the IHS will have improved the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements to at least 82% at the IHS-wide reporting level.

Rationale: It is important that IHS optimize its use of CHS resources. CHS regulations require the use of medical priorities to assure that persons with the most urgent need receive services and that alternate resources pay prior to IHS expending funds. Beyond these built-in requirements, IHS is making efforts to assure that we receive the best price available from our routine providers of care. To that end, we are seeking to ensure that contracts or rate quote agreements are in place that provide reduced rates to IHS and its patients with routinely used hospitals. While not every routinely used hospital will agree to some reduced rate schedule with IHS, many will, and it is to our advantage to continue to aggressively pursue cost-effective arrangements.

Approach: It is not feasible to pursue contracts or agreements with every hospital that provides services to IHS patients. Some hospitals are utilized on a one-time emergency basis when it is impossible for the patient to be moved to a contract facility, or when there is no contract facility in the vicinity. In other cases, the utilization of the facility is so infrequent that it is impractical

to contract with that facility for a small number of patient visits per year. Therefore, IHS is only interested in obtaining contracts or rate quote agreements with frequently used providers. As providers determine that agreements are feasible with the IHS, the percentage should increase.

Frequently used hospitals are defined as those facilities to which IHS paid more than \$50,000 for inpatient services per year and/or more than \$10,000 in outpatient services per year. Not all hospitals meet both criteria, and inpatient and outpatient service contracts and rate quotes will be tracked separately. Those facilities that IHS paid for catastrophic services will be adjusted to further develop valid data on payments for patient services. Changes to reflect calculation based on using amount paid; large amounts related to CHEF cases need to be adjusted from the calculation process for contracts and rate quote agreements. Adjustment of earlier percentage reported to be consistent with the changes due providers who have opted out of HCFA managed care plans.

To calculate the percentage rate we divide the amount paid to frequently used hospital providers with contracts or rate quote agreements, by the amount paid to all frequently used hospital providers, with an adjustment for catastrophic services. The IHS fiscal intermediary (FI), who makes IHS' CHS payments, will provide these amounts. The FI also maintains information on contract and rate quote agreements and applies the contract or agreement rate to the payment. The FI maintains records by individual provider and composite data can be provided.

Data Source: The IHS CHS database collected by Blue Cross and Blue Shield of New Mexico, the IHS Fiscal Intermediary.

Baseline: The IHS will use FY 1997 claims paid data as the baseline. For this year the calculated rate is 74 percent. The reason why the baseline of FY 1997 is chosen is that the data are 99 percent complete.

Type of Indicator: Process

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* the accountability requirements of a DHHS OPDIV, and support H P 2010 objectives in Focus Area 1: Access to Quality Health Services.

Program Performance: No FY 1999 Indicator.

Indicator 39: *No FY 2001 or FY 2002 Indicator*

Indicator 39: During FY 2000, the IHS Headquarters and Areas will maintain full compliance with major Federal requirements (i.e., GPRA, GMRA, Clinger-Cohen Act, etc.), without expanding the administrative staff above the FY 1999 FTE target level.

Rationale: A major recommendation in the IHS reorganization plan was to downsize and streamline the IHS Headquarters and Area Offices and move from controlling and directing to providing consultation and support to I/T/Us. This recommendation supports the continued transition to local control but represents a significant challenge because of the loss of economies of scale in the decentralization process. In the FY 1999 performance plan the IHS committed to

reducing the number of FTE s in IHS Headquarters and Areas by 10 percent over the FY 1997 level.

For FY 2000 the IHS is committing to maintaining the reduced Area and Headquarters administrative FTE level at the target FY 1999 level (i.e., 10% below the FY 1997 level) and to focus resources at providing access to services. Further reductions in administrative positions will be considered with caution given the increasing accountability requirements for which the Agency must be responsive and the importance of field support. Thus, this indicator has not been extended beyond FY 2001.

Approach: To accomplish this indicator the IHS continues the process of reorganizing Headquarters to a flatter and simpler structure and integrating the use of multi-disciplinary teams to address important functions, including the GPRA. Many Areas are also reorganizing to more efficient structures.

As described in Performance Indicator 40, we have been attempting to expand the development of partnerships with outside organizations to bolster our capacity to serve the needs of AI/AN people. Doing more of what is important without expanding administrative overhead will require considerable training and improved technologies, as well as ceasing to expend resources on low value work.

The evaluation of our success in this attempt at achieving more will come from the surveys of I/T/Us described in Performance Indicator 37. Feedback will come from the Department, OMB, and Congress relative to our level of compliance with the growing number of Federal requirements, particularly the GPRA, GMRA, Clinger-Cohen Act, and audits of the resources expended. In the long run, our success in these efforts will be reflected to a considerable degree in the level of realization of our component of the DHHS Strategic Plan and the IHS Mission and Goal.

Data Source: Audits of Area and Headquarters, I/T/U Survey, and feedback from HHS, OMB, and Congress.

Baseline: FY 1997 Area and Headquarters FTEs = 2085

Type of Indicator: Process

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and the accountability requirements of a DHHS OPDIV.

Program Performance: The FY 2000 indicator committed to IHS Headquarters and Areas maintaining full compliance with major Federal requirements (i.e., GPRA, CFO, etc.), without expanding the administrative staff above the FY 1999 FTE target level of 10% below the FY 1997 level (1,876). This indicator has been achieved with the FY 2000 total Area and Headquarters FTEs level of 1,569 while meeting Federal accountability standards. However, the large reduction in FTEs that has occurred with reorganization is greater than anticipated and has left "function holes" in the IHS infrastructure that are essential to replace to assure that the IHS can meet its accountability requirements. Thus, the IHS is discontinuing this indicator following this report for FY 2000.

Indicator 40: *No FY 2001 or FY 2002 Indicator*

Indicator 40: To increase collaborative support for improved health status of AI/AN people, the IHS will have increased the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators over the FY 2000 level.

Rationale: Given the demands in health care that the IHS continues to face, it has become increasingly important to the IHS's advocacy role to seek collaborative partnerships with other organizations that can assist in efforts to achieve the IHS Mission and Goal. While the number of agreements was initially identified as the most appropriate indicator, it has become clear that number is less significant than the area of focus and level of commitment spelled out in the agreement. Thus, this indicator was revised to address increasing the number of agreements specifically directed at performance indicators.

Approach: For many years the IHS has worked collaboratively with other organizations, particularly other HHS agencies (e.g., NIH, CDC, AHCPR), in efforts to improve the quantity and quality of services we provide. The IHS is currently in the process of proactively seeking additional and broader partnerships with organizations directed at setting in place long-term strategic approaches to addressing the interactive effects of health and social services, community empowerment, and economic development directed towards improved quality of life for AI/AN people.

Clearly opportunities exist for expanding agreements with existing organizations as well as developing new ones with other Federal, State and local agencies, as well as private sector organizations. In this light, our Director is currently spearheading a multi-departmental activity for AI/AN children and youth around two themes:

1. Ensuring a safe and healthy home and community
2. Ensuring personal development within the context of developing communities

Response thus far has been encouraging with active participation from HUD, DOI, DOA, DOT, and several HHS OPDIVs. The ultimate goal for the activity is to improve the status of AI/AN children and youth relative to indicators reflecting the two themes. The approach is to collaborate with agencies that serve AI/AN people to improve coordination of services and increase access to services for AI/AN communities (including urban areas). In addition, the initial workgroup for this activity embraced the importance of agencies documenting their commitment to the activity through identifying appropriate specific GPRA performance indicators.

Data Source: Audit of existing agreements.

Baseline: The FY 1999 total number of agreements was 86 as tracked by IHS Headquarters with those linked to performance measures was estimated to be 18. However, the number actually in effect is much greater when Area, and local I/T/U are considered and there is no practical way to secure the nature and number of these agreements.

Type of Indicator: Process

Linkages: This indicator broadly supports the DHHS Strategic Plan, Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives*.

Program Performance: For FY 2000 the IHS committed to increase the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators over the FY 1999 level. This was accomplished when a review of FY 2000 agreements monitored in Headquarters identified 23 agreements addressing performance measures compared to 18 for the FY 1999 agreements. However, this indicator has been discontinued for 2001 and beyond for three reasons. First, a larger number of small single focus agreements have recently been folded into larger multiple focus agreements thus making the number of agreements to have little validity in assessing the actual level of collaboration occurring. Another reason to discontinue this indicator is that while we can and have tracked the agreements negotiated by IHS Headquarters, there is no practical way to do so for the many agreements that are negotiated at Area and local I/T/U levels that are indeed assisting in meeting performance indicators. Lastly, this is a process measure in which the validation and verification is extremely subjective and not consistent with the goal of the IHS moving toward more objective and evidenced-based measures whenever possible.

Indicator 41: During FY 2002, the IHS will continue to expand Managerial Cost Accounting (MCA) capacity through an incremental investment in necessary information technology in accord with DHHS and OMB guidance.

Rationale: The Federal Financial Management Improvement Act of 1996 (The Brown Bill) requires IHS to achieve the linkage of resources to results through MCA. This legislation requires each agency to maintain financial management systems that comply with Federal financial management systems requirements, applicable Federal accounting standards, and the U. S. Standard General Ledger at the transaction level. As mentioned in the *Program Aggregation* section on page 31, caution must be exercised in applying manufacturing accounting approaches to a comprehensive public health program. Attempting to cost account for outcomes for complex chronic disease processes (i.e., diabetes) addressed by many health disciplines in diverse settings, with long time lags in effect, is plagued with threats to validity, and would probably represent an exercise in futility.

Approach: The IHS is analyzing technical alternatives for IHS cost accounting/cost reporting, including a detailed analysis of technical alternatives with cost benefit and trade off analyses. The results will be provided to a partnering group of agency and departmental staff to support strategic decision making regarding the development and implementation of cost accounting at IHS to link resources to results and to generate agency cost reports. The system is necessary to assist IHS leadership in maximizing the effective use of available resources and ensure that patient care can be provided to its customers. Perhaps the most significant benefit or goal for establishing MCA is to increase collections from private insurance, Medicare, and Medicaid.

Type of Indicator: Process

Linkages: This indicator supports the management and accountability requirements of GPRA, GMRA, Clinger-Cohen and a DHHS OPDIV.

Program Performance: The FY 2000 indicator committed to continuing the implementation of Managerial Cost Accounting (MCA) through the development of transitional pilot sites in accord

with DHHS and OMB guidance. This indicator was partially met by implementing 15 new "cost centers" to improve capturing cost by functions, and sponsored 1 of 2 national training on cost principles for staff at service units, areas and headquarters. The indicator also includes completing "cost reports" at 30 facilities and 12 Area Offices to be used for Medicare/Medicaid rate negotiation. Five additional sites were selected to complete first-year practice cost reports. The IHS reviewed the Veterans Administration Hospital financial cost accounting system in Albuquerque, NM, for evaluation and possible adoption by IHS.

Quality of Work Life Indicator:

Indicator 42: For FY 2002, the IHS will improve its overall Human Resource Management (HRM) Index score to at least 98 as measured by the DHHS annual HRM survey.

Rationale: The purpose of this indicator is to improve the quality of work life for IHS employees. The DHHS Quality of Work Life project is based on social-psychological principles that are associated with both organizational effectiveness and improved quality of life for members. As part of this effort, the Department has developed and refined a Human Resource Management (HRM) Index employee survey as a valid measure of management practices that are important to organizational performance. These practices include Morale, Climate for Innovation, Planning and Organization, Communication, and Operational Efficiency. Since the DHHS started conducting the HRM Index surveys in 1991, the IHS sample scores have consistently averaged below the overall average DHHS score which is normalized/adjusted each year to be 100 points. Thus, OPDIV scores below 100 are below the average and visa versa. Given that the elements assessed in this survey are fundamental to achieving the IHS Mission and Goal, the Agency is committed to improving this trend.

Approach: The IHS is now in the process of actively tailoring the implementation of the Department's Quality of Work Life project to its unique and diverse setting. Furthermore, efforts are under way to identify strategies to improve supporting functions such as training, organizational development, and improved communications networks. It is important to acknowledge that customer satisfaction is also a strong determinant of the quality of work life for health care providers. When consumer demand increasingly exceeds the capacity of the health care system to provide services, waiting times can become excessive, services are more restricted, and consumers are more likely to be disgruntled. The result of this pattern, which has been a reality in the IHS in recent years, is often more pressure and demands on providers that lowers their quality of work life and compounds the problem of retaining and recruiting health care staff. Thus, many other indicators in this plan that address access to services are critical to improving the quality of work life for IHS employees.

The Agency believes the proposed enhancements, coupled with the Quality of Work Life project, and restoring access to services will improve morale, communications, job satisfaction, and other factors sufficiently to be reflected in an improved HRM Index score for the IHS in FY 2002.

Data Source: FY 2002 DHHS HRM Survey

Baseline: FY 1999 DHHS HRM Survey Score was 93 for the IHS

Type of Indicator: Process/Impact

Linkages: This indicator directly supports the Department's Quality of Work Life project and generally supports the DHHS Strategic Plan, Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives*.

Program Performance: In FY 2000 performance goal was to improve the IHS HRM Index score to at least 94 and this goal was met with a FY 2000 score of 96. As mentioned in the rationale above, this score is still below the DHHS average of 100 points and meeting and eventually surpassing this level will require a long-term effort that increasingly addresses the issues relating to access to care for consumers.

Self-Determination Support Indicator:

Note, this is a new FY 2002 and FY 2001 Indicator

Indicator 43: During FY 2002, the IHS will support the efficient, effective and equitable transfer of management of health programs to tribes submitting proposals or letters of intent to contract or compact IHS programs under the Indian Self-Determination Act by:

- a. providing technical assistance to all tribes (100%) submitting proposals or letter of intent based on identified areas of need and with specific technical assistance in the area of calculating contract support costs.
- b. reviewing all initial contract support cost requests submitted (100%) using a IHS Contract Support Cost Policy Review Protocol to assure the application of consistent standards in order to assure equitable and approvable requests.

Indicator 43: During FY 2001, the IHS will support the efficient, effective and equitable transfer of management of health programs to tribes submitting proposals or letters of intent to contract or compact IHS programs under the Indian Self-Determination Act by:

- a. developing a technical assistance "needs assessment" protocol for systematically identifying the technical assistance needs of new compacting and contracting Tribes.
- b. develop a Contract Support Cost Review Protocol for systematically and consistently applying the IHS Contract Support Cost Policy to all initial contract support cost requests.

Rationale: The amount of funding appropriated for contract supports costs has increased significantly in the last five years and has grown to approximately \$250 million. The Congress and the Office of Management and Budget have requested that the Indian Health Service continue to review the soundness of its allocation policies concerning contract support costs and to take steps to assure that contract support costs provided to tribes are reasonable and do not duplicate other funding provided to tribes by the IHS under self-determination agreements. The provision of technical assistance to tribes and review of Contract Support Cost requests that is consistent with the IHS Contract Support Cost Policy and the Indian Self-Determination Act will address the concerns of the Congress and the OMB.

Approach: During FY 2001, IHS Headquarters and Area staff and tribal stakeholders will develop protocols for systematically identifying technical assistance needs and reviewing the contract support cost requests of new contracting and compacting tribes. In addition, Area IHS staff responsible for utilizing these protocols will be instructed in their application including training on the provisions of the IHS Contract Support Cost Policy.

During FY 2002, the IHS will utilize these protocols all newly contracting or compacting tribes. The verification that both protocols have been utilized will be documented in the Annual Funding Agreement that is signed by both the tribe and IHS. In the long run, success will be reflected in the greater number of requests that are technically accurate and consistent with the Indian Self-Determination Act and the IHS Contract Support Cost policy and may be included as target for this indicator in future years.

Data Source: Signed Annual Funding Agreements.

Baseline: Not Applicable

Type of Indicator: Process

Linkages: This indicators supports the DHHS Strategic Plan, Strategic Objective 3.6 Improve the Health Status of American Indians and Alaska Natives and the Indian Self-Determination and Educational Assistance Act.

Program Performance: No FY 2000 Indicator.

APPENDIX TO THE IHS 2002 PERFORMANCE PLAN

A.1 Approach to Performance Measurement

Data Verification and Validation

In the context of GPRA the concepts of data validation and verification are defined as:

Validation is the process for ensuring that data collected match the intended area of performance.

Verification is the assessment of data completeness, accuracy, consistency and timeliness and related quality control practices.

For each performance indicator in this performance plan, the issue of validation is directly addressed in the "Rationale" section that comes immediately after the statement of the indicator. Where ever possible we have attempted to use an evidence-base justification for the selection of the indicator, particularly for clinical care related indicators.

How we address the issue of data verification, however, is considerably more diverse in this plan because of the diversity of types of data that support the indicators. The verification of many of the clinically based performance indicators is supported by either the IHS Automated Data System or the IHS Diabetes Care and Outcomes Audit. The verification of data from these sources is described in the three sections that immediately follow and support indicators 1-8, 12, 13, 18, 22-24, 26, 29.

For the Capital Programming/Infrastructure Indicators 34-36, the data are recorded at the local level where projects are conceptualized based in strict protocols and formulas. These data are compiled at the Area and Headquarters level and reviewed for accuracy and then compare against similar projects. The validation and verification of this information is essential to the facilities programs since it is used to distribute resources as well as measure performance.

For indicators that survey our consumers (indicators 21 and 37), the required Paperwork Reduction Act clearance process effectively addresses both validation and verification process as required in submitting the instrument and collection protocol. We are using a similar recognized survey approach to assess Indicator 16 addressing surveys of our health care providers relative to the adoption of policies and procedures for screening and referral for victims of family violence, abuse, or neglect, and staff training that support these policies. Similarly, Indicator 42, which addresses the quality of work life, is collected by HHS staff through recognized survey procedures.

The remaining indicators in this plan are process measures for which verification is less formalized but relatively evident from the description of how the indicators are addressed. In essence they are based on the integrity of IHS reporting structures. As an example, Indicator 20 addressing health facility accreditation, depends on the reports of the accrediting bodies submitted to the sites and Areas, forwarded to IHS Headquarters and reported in this document.

Data Sources to Describe the AI/AN Population

The IHS utilizes outside (non-IHS) and IHS data sources to manage its diverse programs and assess Indian health status. The two principal outside data sources are the Bureau of the Census and the Centers for Disease Control and Prevention, in particular, the National Center for Health Statistics (NCHS). The Census Bureau is the source of Indian population counts and social and economic data. However, reliable Indian census data at the county level are only available from the Decennial Census, once every 10 years. The IHS prepares AI/AN population estimates for years between the Censuses.

The NCHS provides IHS with natality and mortality files that contain all births and deaths for USA residents, including those identified as American Indian or Alaska Native. The NCHS obtains birth and death records from the State departments of health, based on information reported on official State birth and death certificates. The IHS receives these records with essentially the same basic demographic information as the records maintained by NCHS, but with names, addresses, and record identification numbers deleted as required by the Privacy Act. It should also be noted that tribal identity is not recorded in these records by the States. The State of New Mexico does identify tribal affiliation for 23 indigenous tribes of that state. However, the IHS does not obtain this tribal identification from the automated records provided by NCHS. The data are subject to the degree of accuracy of reporting by the States to NCHS. The NCHS does perform numerous edit checks and imputes values for non-responses. The IHS assigns IHS organizational (Area and service unit) identifiers to the birth and death records in setting up its Indian database. The IHS computer routines for accomplishing this have been thoroughly verified, and the results are continuously monitored.

Several studies have shown considerable miscoding of Indian race on State death certificates, understating Indian mortality especially in areas not associated with Indian reservations. The IHS now utilizes factors based on a National Death Index study to adjust Indian mortality rates for race miscoding. Another major problem with mortality data is the time lag in receiving data. These data are not typically available from NCHS until two years after the events occur, and mortality data are often slow in showing the impact of health interventions. Due to these constraints, IHS has chosen not to use mortality data for annual performance plan indicators except in special circumstances. The IHS will continue to use mortality data for tracking long-term trends in Indian health status and to make comparisons with other population groups. However, having to wait two years to link activities in an annual performance plan with mortality findings is of limited value in the ongoing implementation and evaluation process.

IHS Automated Data Systems

The IHS has its own program information systems to collect data on the services provided by IHS and tribal direct and contract programs. The software used by IHS facilities and most tribal facilities is the Resource and Patient Management System (RPMS). In addition the IHS provided the file structure and technical assistance to a number of tribes to facilitate reporting of data in RPMS from non-RPMS sources. As a result, it is estimated that this data set accounts for approximately 90 percent of the IHS user-population.

Data are collected for each inpatient discharge, ambulatory medical visit, and dental visit (all patient specific) and for community health service programs including health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse (all activities reporting systems).

The patient-specific data are collected through the Patient Care Component (PCC) of the RPMS. These data are subject to recording, inputting, and transmission errors. However, IHS applies a series of edits at the facility and central database levels to detect and correct invalid data. Some examples include the following: when ICD-9 and CPT-4 data is input into RPMS, edit checks are conducted for sex, age, and diagnosis to prevent data from being processed that could not be true; the Medical Record supervisors have access to the medical records reports which provide the capability to check the data entered for completeness (e.g., does each visit have a provider, date of service, etc.) and flags the entries that should be edited; and when records are flagged for export, the PCC Export routine has edit checks to prevent transmission of records with incomplete data elements.

At the central database level when data is processed, additional edit checks are applied to ensure that the validity of data sorts. For example, if a report requires the gender and if the gender field is not 'male' or 'female', that record is not used. Reports are also assessed for linearity (is the data consistent month to month) and completeness (how it compares to last year) prior to sending data for review and approval. Others that cannot be detected by computer are identified through the monitoring for reasonableness that is performed in the field, and by Area and Headquarters health program staff.

Each facility that utilizes PCC has a facility-level database that contains the detailed PCC data collected at that site. A subset of the detailed PCC data (to meet the routine information needs of IHS Headquarters) is transmitted to the IHS central database. The PCC data are the source of most of IHS' GPRA measures since they reflect prevention activities and morbidity and do not have the time lags described previously for mortality data. However, many of IHS' proposed measures rely on detailed PCC data not currently transmitted to the IHS central database. The IHS is developing software to transmit some of these needed data items to the central database. In the meantime, IHS will need to use sampling routines to collect the required data from the individual facility-level databases. A stratified sampling approach will be used to include different types and sizes of facilities and Indian populations with different health characteristics.

Early in the process of attempting to compile FY 2000 reports for several indicators based on our automated patient record data system, several unforeseen data problems emerged. As part of our Y2K conversion efforts in 1999, the IHS retired the obsolete mainframe computing platform that was used to aggregate Indian Health Service supported health care data nationally and prepare statistical reports, which are used to report on GPRA indicators. The conversion efforts successfully addressed the Y2K date change issue but proved to be challenging when migrating existing data and duplicating the complex set of algorithms used to aggregate data from decentralized collection points. When the database was transitioned from the mainframe to IBM RS/6000 minicomputers there were incompatibilities between the configuration of the database (Informix) and the IBM High Availability hardware configuration that resulted in data being lost during report generation or the verification processes were not fully functional.

Intensive efforts have since been focused on procedures to reestablish the essential report generating capabilities and ultimately improve data quality. Many of the problems have been addressed by moving the database to the IBM Database 2. Due to hard drive failures, space limitations and equipment upgrades annual report verification was delayed. All of these hardware/equipment issues will be completely addressed by the end of March 2001. Additionally, there are issues with duplicate patient data and complete export of data from field

sites. The Master Person Index and Data Movement projects should eliminate most of these problems sometime in FY2002.

There are currently workgroups formed (with IHS Direct, Tribal and Urban staff) to address issues of workload reporting, algorithm/formula review, data entry/coding, equity, etc. Within the next year, these groups will develop solutions to improve the quality and timeliness of our data. This has been and is a challenging process requiring a high level of coordination and cooperation between the local I/T/Us, Areas and to Headquarters.

The combination of improvements in the information technology architecture and the program improvements will ultimately improve the quality and availability of data. Current efforts are focused on securing data for indicator 26 not yet reported and on final data validation and verification for six other indicators (Indicators 1, 6-8, 13 and 22). We are confident these technical set backs will be resolved and we remain committed to improving the processes for generating and making GPRA and other accountability data a major focus of our information technology development path.

IHS Diabetes Care and Outcomes Audit

A final important data set that underpins the diabetes treatment indicators 2-5 is the IHS Diabetes Care and Outcomes Audit. Since 1986 a yearly medical record review to assess diabetes care has been conducted in more than 75% of the IHS and tribal facilities, representing care to nearly 70,000 AI/AN people with diabetes. The medical staff at participating facilities are encouraged to maintain active diabetes registries using uniform definitions. Each registry is maintained in the IHS medical record system and includes information about individuals with diagnosed diabetes who have been seen at least once in the past three years. Each year a systematic random sample is drawn from each facility's registry, using a sample size sufficient to provide estimates of $\pm 10\%$ of the true rates of adherence for that facility with a confidence of $>90\%$.

The medical record review measures selected clinical interventions, performance measures, and intermediate outcomes using the uniform set of definitions. The Area diabetes consultants conduct chart reviews and other professional staff trained by them in accordance with written instructions and definitions provided by the IHS Diabetes Program. The abstracted data are entered into a microcomputer-based epidemiologic software program. Summary reports are printed for immediate use by facility staff in their quality improvement and program planning Activities. Regional and national rates are constructed for each item of the medical record review after data are aggregated from all participating sites.

During the period 1995-1999, approximately 150 sites submitted data to be compiled for the IHS total. Indian health facilities and tribally contracted facilities that do not provide direct patient services did not participate in the audit. Participation from each of the 12 IHS administrative regions varied by year and by federal or tribal management. All regions were represented in each year and approximately 2/3 of all the facilities contributed data in a given year. Tests of trend over the 3- year period were performed by the Mantel-Hanzel test except as noted in the text.

A.2 Changes and Improvements

FY 2002 Performance Plan

The IHS has drafted its FY 2002 performance plan is based on updates in baseline data and other data related issues, the ability to address key external factors influencing success (see Section 1.4 on page 24), the level of attainment of related FY 1999 performance indicators, and the most current proposed funding level. The IHS has discontinued two indicators for both FY 2002 and FY 2002. The first is indicator addressing downsizing and maintaining a smaller administrative infrastructure while maintaining compliance with accountability requirements. This decision was based on a potential need for some increases in infrastructure to address the growing accountability requirements of Federal agencies.

The second indicator addressed increasing the number of agreements with other organizations that directly support GPRA performance indicators was discontinued for several reasons. First, a larger number of small single focus agreements have recently been folded into larger multiple focus agreements thus making the number of agreements to have little validity in assessing the actual level of collaboration occurring. Another reason to discontinue this indicator is that while we can and have tracked the agreements negotiated by IHS Headquarters, there is no practical way to do so for the many agreements that are negotiated at Area and local I/T/U levels that are indeed assisting in meeting performance indicators. Lastly, this is a process measure in which the validation and verification is extremely subjective and not consistent with the goal of the IHS moving toward more objective and evidenced-based measures whenever possible.

Six indicators have been added to the FY 2002 plan including:

- two new treatment indicators covering access to dental services for diabetics and reducing untreated dental decay in youths
- two prevention performance indicators covering HIV risk behavior and expanding tribal infrastructure for comprehensive injury prevention
- a new data related indicator for improving data quality and expanding information technology capability in collecting and monitoring GPRA clinical performance data.
- a new indicator addressing tribal Self-Determination support and Contract Support Costs

As part of efforts to continually improve performance data, the IHS will utilize a systematic sampling approach for several clinical indicators during the FY 2001. This sampling process will be used to validate recently developed automated data runs and identify problem areas in coding and collation of data with the goal of greater use of automated approaches in the near future.

Another improvement to the FY 2002 Performance Plan is the application of the Balanced Scorecard model. A discussion of this model has been included on pages 36-38 of this document that explains the use of the Balanced Scorecard in the Federal context. Furthermore, each performance indicator is classified as to which perspective of this construct it best fits under the heading of "Type of Indicator" that is included with the description of each individual indicator.

FY 2000 Performance Report

For FY 2000, of the 34 performance indicators in the plan we are now reporting on 29, with six are provisional findings pending further verification. Of these 29 indicators, 18 were achieved, nine partially achieved, and two not achieved. We will report on the remaining five indicators by this coming August.

Revisions to FY 2001 Performance Plan

The iterative process of developing the FY 1999-FY 2001 performance plans and drafting the FY 1999 performance report has been a significant learning process for the IHS. It has required the auditing of many different data sets to assess current access to health services (coverage) and baseline rates of various conditions. As part of efforts to continually improve performance data, the IHS will utilize an electronic sample procedure for three clinical indicators (Indicators 6,7 and 24) during FY 2001, and verify and validate this approach against a chart audit of a subset of the sample. This sampling and audit process will identify problem areas in coding and collation of data with the goal of greater use of automated approaches in the near future. In light of these findings, the IHS has revised several indicators for FY 2001 to assure more reliable, timely and accurate performance data.

In addition, analyses of recent workload data have revealed that expanding access to some services will be likely to be affected by the growing problems in recruiting and retaining health care providers (see *Recruitment and Retention of Health Care Providers* on page 28). Based on these trends and the IHS FY 2001 funding level, we have adjusted the target levels of a few indicators to reflect more realistic probabilities of accomplishment for FY 2001.

For two indicators our efforts in FY 2000 have resulted in our ability to set higher performance targets in FY 2001 than originally proposed. Our success in achieving a higher score in the HHS Quality of Work-life survey for FY 2000 allowed us to raise the FY 2001 target from 95 points to 97 for Indicator 42. From a public health perspective, we are pleased that our efforts in FY 2000 in improving water fluoridation compliance in pilot sites through an agreement with CDC has resulted in increased focus and earmarked funding for FY 2001. As a result all Areas will benefit from this effort and the performance target for improved access to fluoridated water in FY 2001 is expanded beyond the pilot sites to include all IHS Areas.

This process has also identified opportunities for greater cooperation with outside entities such as CDC and NIH and indicators have been revised to build on these partnerships in addressing tobacco use, HIV/AIDS, and cardiovascular disease.

The table that follows summarizes the significant changes in content or magnitude to FY 2001 indicators originally submitted with the FY 2001 budget.

Original FY 2001 Indicator	Revised FY 2001 Indicator	Rationale for Change
Indicator 17: Not included	Indicator 17: During FY 2001, IHS will: <ul style="list-style-type: none"> • Conduct a pilot study at five sites to evaluate the potential of electronically extracting data from the RPMS to report on five clinical performance measures, • Begin one or more intervention studies at appropriate sites to resolve data quality problems that are identified in this and previous studies, • For any of these performance measures where the data quality is deemed to be sufficient to proceed, implement electronic data collection so that baseline data can be collected for FY 2002. 	This indicator was added to support ongoing efforts to improve performance data quality and expanding automated approaches to data collection.
Indicator 21: By the end of FY 2001, improve IHS-wide consumer satisfaction by 5% over the FY 2000 baseline level	Indicator 21: By the end of FY 2001, secure OMB clearance on revised consumer satisfaction instrument.	Submission to OMB was not completed during FY 2000 because of revisions of the instrument and has delayed clearance until FY 2001, and collection of baseline until FY 2002.
Indicator 22: Improve the health status of American Indian and Alaska Native people by assuring that during FY 2001, the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits are increased by 7% over the FY 2000 workload levels.	Indicator 22: Improve the health status of American Indian and Alaska Native people by assuring that during FY 2001, the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits are increased by 3% over the FY 2000 workload levels.	Performance level adjusted to reflect the continued problem of recruitment and retention of health care providers and to reflect the IHS FY 2001 appropriation.
Indicator 23: Reduce the incidence of preventable disease by increasing the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) during FY 2001 by 2% over the FY 2000 rate.	Indicator 23: Reduce the incidence of preventable disease by increasing the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) during FY 2001 by 1% over the FY 2000 rate.	Performance level adjusted to reflect the continued problem of recruitment and retention of health care providers.

Original FY 2001 Indicator	Revised FY 2001 Indicator	Rationale for Change
Indicator 17: Not included	Indicator 17: During FY 2001, IHS will: <ul style="list-style-type: none"> • Conduct a pilot study at five sites to evaluate the potential of electronically extracting data from the RPMS to report on five clinical performance measures, • Begin one or more intervention studies at appropriate sites to resolve data quality problems that are identified in this and previous studies, • For any of these performance measures where the data quality is deemed to be sufficient to proceed, implement electronic data collection so that baseline data can be collected for FY 2002. 	This indicator was added to support ongoing efforts to improve performance data quality and expanding automated approaches to data collection.
Indicator 21: By the end of FY 2001, improve IHS-wide consumer satisfaction by 5% over the FY 2000 baseline level	Indicator 21: By the end of FY 2001, secure OMB clearance on revised consumer satisfaction instrument.	Submission to OMB was not completed during FY 2000 because of revisions of the instrument and has delayed clearance until FY 2001, and collection of baseline until FY 2002.
Indicator 22: Improve the health status of American Indian and Alaska Native people by assuring that during FY 2001, the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits are increased by 7% over the FY 2000 workload levels.	Indicator 22: Improve the health status of American Indian and Alaska Native people by assuring that during FY 2001, the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits are increased by 3% over the FY 2000 workload levels.	Performance level adjusted to reflect the continued problem of recruitment and retention of health care providers and to reflect the IHS FY 2001 appropriation.
Indicator 23: Reduce the incidence of preventable disease by increasing the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) during FY 2001 by 2% over the FY 2000 rate.	Indicator 23: Reduce the incidence of preventable disease by increasing the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) during FY 2001 by 1% over the FY 2000 rate.	Performance level adjusted to reflect the continued problem of recruitment and retention of health care providers.

Original FY 2001 Indicator	Revised FY 2001 Indicator	Rationale for Change
Indicator 24: Reduce the incidence of preventable diseases, by increasing pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 2% over the FY 2000 rates.	Indicator 24: Reduce the incidence of preventable diseases, by increasing influenza vaccination levels among adult diabetics and adults aged 65 years and older by 1% over the FY 2000 rates and securing baseline pneumococcal vaccination rates for this population.	Performance level adjusted to reflect the continued problem of recruitment and retention of health care providers and securing reliable assessments of pneumococcal vaccination rates. Data for this indicator are now collected by the use of electronically drawn random sample of patient records with verification of a subset by chart audit as part of a transition to more automated approaches to securing performance data. See the indicator write-up (pages 84-86) for description of this process.
Indicator 28: Improve physical fitness and model fitness behavior by assuring that by the end of FY 2001, at least five model Take Charge Challenge fitness programs will be organized and functioning at either IHS Area Offices or the I/T/U level.	Indicator 28: During FY 2001, the IHS will collaborate with NIH to assist three AI/AN communities develop culturally sensitive, multidimensional, community - directed pilot cardiovascular disease prevention programs.	This indicator has been modified to have a longer-term less prescriptive focus targeting the prevention of cardiovascular disease that will build on collaborative efforts already underway with NIH at three AI/AN pilot sites.
Indicator 31: Reduce high risk HIV/AIDS behaviors by assuring that at least 50% of the I/T/Us will have implemented an HIV/AIDS Needs Assessment to monitor and assess risks by individuals and tribal communities and develop appropriate interventions.	Indicator 31: During 2001, develop an approach for HIV/AIDS surveillance and establish a baseline for completeness of reporting in one IHS Area.	Indicator 31 was revised and Indicator 32 was added after analyses of available data revealed serious deficiencies in HIV/AIDS reporting across states and difficulties in comparing IHS and CDC data sets. In addition, through an interagency agreement with CDC, an experienced HIV/AIDS coordinator has joined the IHS and is refocusing efforts to enhance surveillance, long-term program effectiveness, and collaborative partnerships.
Indicator 32: No Indicator Proposed Initially	Indicator 32: Obtain a baseline measure of the percentage of high risk sexually active persons who know their HIV status from a sample of IHS facilities.	See Explanation for Indicator 31 above.
Indicator 33: Reduce environmental threats to health by completing community environmental assessments of 90% of American Indian and Alaska Native communities in FY 2001 by the implementation of the environmental health surveillance system.	Indicator 33: By the end of FY 2001, complete field-testing of the protocol and implementation plan for an environmental health surveillance system and conduct environmental assessments in 15% of American Indian and Alaska Native communities.	Performance level adjusted to reflect the IHS FY 2001 appropriation and vacancies in critical staff during FY 2000 that delayed progress. In addition, Tribal consultation is requiring greater time than anticipated.

Original FY 2001 Indicator	Revised FY 2001 Indicator	Rationale for Change
<p>Indicator 35: Improve home environmental health by providing sanitation facilities projects to serve 3,800 new or like-new homes and 11,455 existing Indian homes.</p>	<p>Indicator 35: Improve home environmental health by providing sanitation facilities projects to serve a total of 14,730 new or like-new homes and existing Indian homes.</p>	<p>Performance level adjusted to reflect the IHS FY 2001 appropriation.</p>
<p>Indicator 36: ; Improve critically needed access to health care services by providing the following physical infrastructure:</p> <ul style="list-style-type: none"> • Ft. Defiance, AZ Hospital: Continue construction of the replacement hospital and start design of part of the staff quarters; • Winnebago, NE Hospital: Continue construction of the replacement hospital. • Parker, AZ Health Center: Continue construction of the replacement health center. • Pawnee, OK Health Center: Start design of the replacement health center. • Small Ambulatory Construction Grants: Provide construction grants to tribes/tribal organizations. <p>Dental Units: Provide dental units based on priority needs.</p>	<p>Indicator 36: ; Improve critically needed access to health care services by providing the following physical infrastructure:</p> <p>Hospitals: Ft. Defiance, AZ-Constr..... Winnebago, NE-Constr.....</p> <p>Outpatient Care Fac.: Parker, AZ-Complete Constr..... Pawnee, OK -Complete Design.....</p> <p>Staff Quarters: Bethel, AK.....</p> <p>Joint Venture Projects: Equipment for tribally constructed projects</p> <p>Small Ambulatory Grants: Construction grants/contracts to tribes/tribal organizations</p> <p>Dental Units: Modular dental units</p>	<p>Performance level adjusted to reflect the IHS FY 2001 appropriation.</p>
<p>Indicator 37: To improve the IHS consultation process with its I/T/U stakeholders, during FY 2001 the IHS will implement the revised consultation policy and secure OMB clearance for the instrument to assess I/T/U stakeholder satisfaction with the consultation process.</p>	<p>Indicator 37: To improve the IHS consultation process with its I/T/U stakeholders, during FY 2001 the IHS will coordinate the completion and implementation of the revised IHS consultation policy and develop an instrument to assess satisfaction with the new policy.</p>	<p>Efforts to integrate diverse strategies for revising the consultation policy proposed by different stakeholder groups have resulted in a delay in the revision process start-up.</p>

Original FY 2001 Indicator	Revised FY 2001 Indicator	Rationale for Change
Indicator 38: During the FY 2001 reporting period, the IHS will have improved the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements to at least 88% at the IHS-wide reporting level.	Indicator 38: During the FY 2001 reporting period, the IHS will have improved the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements to at least 79% at the IHS-wide reporting level.	Follow-up review of the FY 1997 data that the baseline was drawn from revealed that the original baseline analysis did not account for large amounts paid for single large payments out of the Catastrophic Health Emergency Fund, or adjustments for providers who have opted out of HCFA managed care programs. Thus, a new lower baseline has been calculated and targets have been reduced correspondingly.
Indicator 40: To increase collaborative support for improved health status of AI/AN people, the IHS will have increased the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators over the FY 2000 level.	Indicator 40: This Indicator has been discontinued for FY 2001.	With a larger number of agreements being folded into larger single agreements, the number of agreements now has little validity for assessing the level of collaboration. In addition, it was discovered that there is a large number of agreements at the Area and local level that are not monitored in a centralized way.
Indicator 39: During FY 2000, the IHS Headquarters and Areas will maintain full compliance with major Federal requirements (i.e., GPRA, GMRA, Clinger-Cohen Act, etc.), without expanding the administrative staff above the FY 1999 FTE target level.	Indicator 40: This Indicator has been discontinued for FY 2001.	Given growing accountability requirements and identified limitations in IHS public health infrastructure, this indicator may no longer be valid in supporting the IHS Mission, Goal, and Foundation..
Indicator 42: To improve job satisfaction and the quality of work life for IHS employees, the IHS will improve its overall Human Resource Management (HRM) Index score to at least 95 as measured by the DHHS annual HRM survey.	Indicator 42: To improve job satisfaction and the quality of work life for IHS employees, the IHS will improve its overall Human Resource Management (HRM) Index score to at least 97 as measured by the DHHS annual HRM survey.	The target has been raised for FY 2001 to build on the success of the score of 96 accomplished in FY 2000.
Indicator 43: : No Indicator Proposed Initially	Indicator 43: During FY 2001, the IHS will support the efficient, effective and equitable transfer of management of health programs to tribes submitting proposals or letters of intent to contract or compact IHS programs under the Indian Self-Determination Act by: a. developing a technical assistance "needs assessment" protocol for systematically identifying the technical assistance needs of new compacting and contracting tribes. b. develop a Contract Support Cost Review Protocol for systematically and consistently applying the IHS Contract Support Cost Policy to all initial contract support cost requests.	The indicator has been added to enhance focus on technical assistance to compacting and contracting tribes and assure the consistent application of the IHS Contract Support Cost Policy in reviewing contract support cost requests.

A.3 Linkage to HHS and OPDIV Strategic Plans

The IHS FY 2001 Plan was developed in the context of the IHS component of the HHS Strategic Plan and the four broad strategic objective described in Section 1.1. From the perspective of the HHS Strategic Plan, every indicator selected directly or indirectly supports Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives*. Furthermore, most indicators also address multiple other Department objectives and are listed in the "Linkages" section of each individual indicator.

A.4 Performance Measurement Linkages with Budget, Cost Accounting, Human Resources, Information Technology Planning, Capital Planning and Program Evaluation

Performance Measurement Linkages with Budget

One of the greatest challenges of implementing the GPRA in a public health program is responding to the requirements of demonstrating an outcome focus on one hand and better linkages to funding (and hence, costs) on the other. These are difficult and in some cases impossible goals to mutually accomplish. The IHS has integrated the use of process, impact and a few outcome indicators but because many health outcomes cannot be realized in a one-year plan, we have predominantly focused on activities that have an evidenced-based association with positive health outcomes over time (impact).

To attempt to enhance short-term detailed cost accounting as well as discipline specific outcome assessment capability would require the reprogramming of a significant proportion of resources away from patient care into administrative infrastructure. Such an effort would run against current trends and existing priorities. We contend given these realities, our plan meets the requirements and intent of the GPRA and adequately strengthens the connection between showing how health care funding is annually prioritized to the problems of greatest concern of our consumers. Health outcomes (i.e., mortality and morbidity) are well articulated annually in our publication *Trends in Indian Health*, but which present data that are two to three years old because of delays in the Nations data system infrastructure.

The IHS has elected to keep general reference to funding levels in the plan and built estimated accomplishment around the request funding level. We can identify which requested funding enhancements are generally linked to supporting specific indicators in some cases. While the linkage would be relatively clear and direct in the case of public health nursing or dental care related indicators, it would get more complex with the diabetes-related indicators and extremely vague in the case of consumer and employee satisfaction related indicators. Applying a linear single path manufacturing accounting model to many health problems and management issues in a comprehensive public health program such as the IHS is not feasible.

Similarly, while performance targets for indicators addressing facilities construction are linked to funding levels in a linear way, this is often not the case for indicators addressing health care services when viewed through a one-year timeframe. Our ability to recruit additional health care providers and having the needed clinical space available to utilize them efficiently may not be realized in a

single year. In some cases, investments in the supportive infrastructure are the highest priority for long-term effectiveness but will do nothing in the short-run to increase access to services.

Another important fact that should be considered in reviewing FY 2002 performance indicators and their targets and the FY 2000 performance results is that the AI/AN population increases over two percent annually. Thus, service capacity must be increased over two percent just to remain at the same level of coverage each year for the indicators that set a target for the percent of the population covered.

We have selected an aggregation approach largely based on the way our programs are managed and have selected four functional areas for the aggregation of the 24 budget categories identified in the IHS "Detail of Change Table": 1.) Treatment, 2.) Prevention, 3.) Capital Programming/Infrastructure, and 4.) Consultation, Partnerships, Core Functions, and Advocacy.

While this approach may appear to be an overly simplistic "lumping" of categories, it is important to realize that there is no aggregation or disaggregation that allows mutually exclusive activities linked to mutually exclusive health problems. For a more detailed discussion of these issues, see the *Program Aggregation* section on page 37 of this document.

Cost Accounting

Beginning in FY 1997, the IHS contracted with the Mitretek Systems to analyze technical alternatives for IHS cost reporting/cost accounting. This provided a detailed analysis of technical alternatives and a cost benefit and trade off analysis of alternatives. The results have been provided to a steering committee to support strategic decision-making regarding the implementation of cost reporting and cost accounting at IHS. This system is necessary to assist IHS leadership to maximize the utility of available resources by being cost effective and ensuring that patient care can be provided to its customers.

In August of FY 1999 the steering committee met during to review, revise, and expand the cost center structure of the agency. All the current 95 cost center specifications were reviewed for content and current applications. The workgroup recommended that some of the current cost centers be deleted in future years. Several new cost centers were recommended for development. These reflect current technology, terminology and healthcare practices that will further help to delineate the agency's costs. During FY 2000 activities included the implementation of 15 new "cost centers" to improve capturing cost by functions, and sponsored 1 of 2 national training on cost principles for staff at service units, areas and headquarters. The effort also included completing "cost reports" at 30 facilities and 12 Area Offices to be used for Medicare/Medicaid rate negotiation. Five additional sites were selected to complete first-year practice cost reports. The IHS also reviewed the Veterans Administration Hospital financial cost accounting system in Albuquerque, NM, for evaluation and possible adoption by IHS.

Human Resources

The IHS is committed to human resource development as an essential component of performance planning and performance management. Historically, we have consistently invested in long and short-term training in the clinical, public health, and management/leadership areas to assure capable providers and public health leaders. In recent years we have reduce these investments to in order to support other priorities. The effects of these reductions in training are undoubtedly multiple but perhaps most evident in growing staff retention difficulties. That these two problems

are related was confirmed in surveys of employees leaving the IHS, who indicated that a lack of training opportunities was a significant determinant in their decision to leave.

Across budget categories in the requested FY 2002 IHS budget is a renewed commitment to find cost effective approaches to better meeting human resource development needs including clinical, public health, management, information technology, and teamwork. Through our Quality of Work Life project, the IHS has attempted to align its performance goals with its human resource management efforts in several ways. One, IHS has began a process by which future executives are identified and trained to take over top leadership positions one they become available. Primarily, the use of candidate development programs at all levels is the process that we will be using. Two, there is a large push to train our present and future leadership cadre at the lower levels by offering courses like Leadership in Context which focuses on leadership behavior at all levels, and Leadership 2000 which focused on leadership behaviors at the individual contributor level. Three, we are planning to train a cadre of internal consultants/coaches to offer support and infrastructure to the change in culture that will be needed for the future of Indian health. Four, there is a major push toward flexibility in working conditions for all employees, like flexiplace, flextime, etc.

We use the Human Resource Management Index (HRMI) to determine if our Human resource program is meeting employee and management expectations. The HRMI measures 14 different work related issues ranging from management culture to employee morale. The IHS HRMI score has been identified as a performance measure in beginning with the FY 2000 IHS Performance Plan (see Indicator 42 on page 117) and we expect to raise the HRMI score by at least one point each year to document performance improvement.

Information Technology Planning

The Clinger-Cohen Act (CCA) of 1996 (formerly the Information Technology Management and Reform Act), established new requirements for the information technology (IT) planning process that emphasize the management of IT resources as a "capital investment" and link these IT planning activities to budget and performance measures. The Act reflects the growing importance that the management of IT resources plays in contributing to efficient government operations. The IHS is working to integrate CCA activities in support of GPRA efforts and visa versa.

The IHS budget formulation process is the mechanism through which the portfolio of IT investments is selected and funded. Increased attention needs to be given to the economic and business justification of major investments. During the budget execution phase, an intensified management control process will be established to ensure performance goals are achieved, and that IT projects are delivered on time, within budget, and perform as intended.

The establishment of an IT investment review process as required by CCA represents a major paradigm shift in IT planning, acquisition and management. Because of this, IHS efforts have focused on educating I/T/Us in the new IT management process and providing technical guidance in the development of IT management processes consistent with their operational and management environments.

During FY 2001, the IHS will implement an agency-wide IT Investment Review Board (ITIRB) and policies and procedures on IT capital planning and investment control processes in accordance with CCA requirements and Departmental guidelines. The IHS' approach to CCA

implementation will follow the example of the Department in delegating responsibility and authority to the Area Directors for Area IT capital planning and investment control.

As part of the requirements of GPRA and the CCA, performance measurement is an essential part of effective management. CCA requires IHS to measure the contribution of IT investments to mission results. A key goal of the CCA is for agencies to have processes and information in place to ensure that IT projects are implemented at acceptable costs, within reasonable and expected time frames, and are contributing to tangible, observable improvements in mission performance. To effectively link strategic and IT capital planning along with the budget process, IT performance measurement efforts must monitor the performance of IT investments/projects to address whether they are effectively supporting the mission and programs of IHS.

Capital Planning

Capital asset planning for health care facilities construction is done in accordance with the IHS Health Care Facilities Priority System Methodology and submitted to OMB through Circular A-11, Preparation of Budget Estimates, Section III for reporting capital assets. These issues are represented in this performance plan by the three Capital Programming/Infrastructure Indicators 34-36 beginning on page 103.

Program Evaluation

In recognition of the growing importance of evaluation in supporting the IHS Mission, Goal and GPRA performance planning, the IHS has elected to add this section addressing program evaluation for FY 2000. The IHS evaluation process seeks to include American Indians and Alaska Natives as primary stakeholders in defining the purpose, design, and execution of evaluations. Stakeholders are the users of the end product of evaluations and typically are the population or groups most likely to be affected by the evaluation findings. The IHS has worked with its stakeholders in identifying and implementing principles of responsive evaluation practice and setting evaluation priorities.

The purposes of IHS evaluation efforts are:

- to advise the Director of the IHS on policy formulation; to conduct and manage program planning, operations research, program evaluation, health services researches, legislative affairs, and program statistics
- to develop the long-range program and financial plan for the IHS in collaboration with appropriate agency staff
- to coordinate with HHS, Indian Tribes, and organizations on matters that involve planning, evaluation, research and legislation
- to develop and implement long-range goals, objectives, and priorities for all activities related to resource planning and allocation methodologies and models.

The Office of Public Health (OPH) serves as the principal advisory office to the IHS on issues of national health policy and coordinates these four evaluation functions:

- *Health Program Evaluations*--Collect and analyze information useful for assisting IHS officials in determining the need for improving existing programs or creating new programs to address health needs.

- *Policy Analysis*--Conduct analyses when a change in the IHS health service delivery system must be considered, when issues emerge in an area where no policy currently exists, or when current policies are perceived as inappropriate or ineffective.
- *Health Services Research*--Undertake analyses of the organization, financing, administration, effects, and other aspects of the IHS.
- *Special Studies and Activities*--Conduct studies and prepare special reports required by Congress in response to pending legislation or policies, often using a roundtable whenever an issue or a health problem requires immediate action and it is unclear what type of action should be taken.

The OPH meets part of the IHS evaluation needs with two major types of short-term studies: policy or program assessments and evaluation study. The policy study contributes to IHS decision-making about budget, legislation, and program modifications and includes background information to support IHS projects. Evaluation studies are carried out at the program level, or area offices, and focus on specific program goals.

Annually, OPH identifies the high-priority health care and health management issues and concerns through the submission of headquarters and area office proposals for assessment or evaluation. IHS area and associate directors submit proposals for possible areas of evaluation study. These proposals are reviewed and rated by a panel of subject-matter experts and evaluation experts and also reviewed by IHS staff for more specific concurrence with IHS strategic goals, objectives, and priority areas. The proposals are then ranked by priority and forwarded to the OPH for review and approval. The Director of the IHS reviews the final proposals and decides the respective funding levels.

Summary of Relevant Evaluations Activities

Several recent evaluation projects have significant direct and/or indirect implications for IHS performance planning and are thus summarized below:

Level of Need Funded Study Part 1: Benefit Package Costs for All Indians: This study, which is currently in draft report status, was designed to answer the question: *What would it cost to provide an equitable level of health care services to all eligible Indian people?* The research team used an actuarial analysis approach to address factors that affect the cost of providing health care benefits. The Federal Employee Health Benefits Plan was used as the benchmark for coverage and cost (i.e., premiums, co-payments, and deductibles) and adjustments were made for the population's age, health status, location, and estimated payments by other insurers (i.e., Medicare, Medicaid, and private).

The finding revealed that a health care package comparable to the Federal employee's provided to all 2.4 million AI/AN would cost \$2,980 per person for a total cost of \$7.4 billion annually. This same coverage if applied to the current 1.34 million using the IHS system would cost approximately \$4 billion with about 25% of the cost expected to come from other sources (i.e., Medicare, Medicaid, and private). Under this model, additional resources would be needed to serve all eligible AI/AN people.

Diabetes in the Native American Population: The purpose of this project is to evaluate the effects of intensive counseling and drug management on the lowering of HgA1c's hypertension

control and compliance with annual exams through a pharmacy practitioner diabetes program. The current Santa Fe Service unit (SFSU) HgA1c average is 8.3%. This is a reduction from 9.4% in 1995. It has been suggested that this reduction is due to the increased use of metformin at the SFSU. The cost of this agent for the past 2 years at SFSU alone totaled \$45,303. The estimated cost of all diabetic medication in FY 97 was \$31,750. The proposed use of another new agent troglitazone has the potential of triple this dollar amount. The project will attempt to limit these expenses by providing intensive counseling on the use of medications, reinforcing dietary and lifestyle changes and recommended by the dietician, reinforcing the use of self-blood glucose monitoring, and adjusting medication per protocol or doctors orders. The findings from this study underpin many of the strategies used in to achieve Indicators 2-5.

Evaluation of the Behavioral Risk Factor Surveillance System's Results and their

Applicability to the Native Population of Anchorage: The purpose of this evaluation study is to determine the relative accuracy, validity and reliability of the Behavioral Risk Factor Surveillance System (BRPSS) risk estimates of the Anchorage Native population compared with data collected using other techniques that include (a) door-to-door household surveys, (b) key informant surveys, and (c) intercept data collection from Natives seeking primary care services in Anchorage from the Alaska Native Medical Center and the Primary Care Center.

The findings have significant implications for the most efficient and effective approaches to delivering health services and thus achieving many of the performance measures in this plan.

Evaluating the impact of primary intervention techniques on the dental caries rate in children living in southwest Alaska Native villages: The project will identify the reason why some communities in Bristol Bay have significant higher/lower caries rates in children than do other children in other Bristol Bay communities. Children aged 6-8 have been selected for the project. Since there are multiple contributing factors from caries, multiple risk factors must be reviewed to properly assess the risk for disease. The results of the project will be used to identify the factors that create high risk communities. A community model will be developed for use in allocating specific techniques including use of fluoridated water, consistent topical fluoride application, village education and support will reduce decay by an average of 2-3 surfaces per child at the end of those years.

Alaska Native Teen Tobacco Cessation Project: The purpose of the Alaska Native Teen Tobacco Cessation Project is to (1) help the youth who participate in the project to quit tobacco, 2) motivate the youth to become tobacco prevention and cessation advocates in their communities, and 3) determine the effectiveness of the cessation camp model in helping youth to quit tobacco. The utility of the study is to provide health educators, parents, teachers, community health aids, and other community health workers with information about the effectiveness of this particular approach to teen tobacco cessation.

This project will provide important information and strategies relevant to the development of Tobacco Control Centers as outlined in Indicator 30.

Assessing Substance Abuse Treatment Outcomes for Native Americans Residing on the Reservation: This study will provide a description of the severity of the participants' problems across eight domains (medical, legal, employment, social, drug use, psychological and spiritual) prior to intervention, and for up to 24 months after intervention. This description will provide the basis upon which improvements of the treatment program can be made. Areas that should be

targeted for specific populations will be identified. In addition, the study will produce a set of manuals documenting the interventions provided by Indian Rehabilitation, Inc., in a manner that will allow replication by other facilities.

Methodology for Adjusting IHS Mortality Data for Inconsistent Classification of Race-Ethnicity of American Indian and Alaska Natives Between State Death Certificates and IHS Patient Registration Records: The findings in this study indicate that on 10.9 percent of IHS Indian records matched to national death records, the race reported for the decedent was other than American Indian or Alaska Native. The percentage of records with inconsistent classification of race varied considerably among the IHS Areas. Recommendations included replicating the study using data on deaths occurring since 1988, using the adjustment factors developed in the study, and working with States to decrease inconsistent race reporting. While the significance of the study is not profound in terms of the performance indicators in this plan (i.e., the indicators are not based on State death certificates), the long-term significance in monitoring mortality disparities for the AI/AN population is critically important. The adjustments factors developed from this investigation are now being utilized in calculating AI/AN mortality rates in all the IHS publications.

Evaluation of the Indian Health Service (IHS) Adolescent Regional Treatment Centers: The principal conclusion based on this study's findings is that regional treatment centers have developed effective adolescent alcohol and substance abuse programs. The continuity of care and aftercare, however, is the biggest problem. The regional treatment centers need additional mental health staff resources, client charting improvements, and innovative ways to increase family involvement. Recommendations include improving the continuum of care to adolescent substance abusers, self-evaluation, and regional treatment center effectiveness and efficiency. This evaluation effort served as a major determinant in selecting Indicator 9 for this plan that addresses follow-up care for youths returning from regional treatment centers.

Evaluating the Effectiveness of Alcohol and Substance Abuse Services for Native American and Alaska Native Women: Phase II Final Report: This evaluation provides both qualitative and quantitative information about a group of women that has been traditionally underrepresented in research. The life conditions of women about whom information was gathered are extreme, and for many women, adverse or abusive childhood experiences and conditions have carried through to adulthood. The vast majority of women were exposed to various types of abuses--such as physical, sexual, and emotional abuse--from childhood to adulthood. Women entered treatment through a variety of ways. Those who were mandated tended to enter treatment as an alternative to incarceration. Women hear about the availability of services through the court system, word-of-mouth, or through a community or an American Indian and Alaska Native social service agency. Women in the focus groups tended to select their current alcohol and other drug treatment program over alternatives because of its focus on American Indian and Alaska Native tradition and culture. The women and staff also espoused the benefits of the family-like environment that the treatment centers promoted. The availability of women-centered, family-focused approaches to alcohol and other drug treatment is severely limited in the United States. Several barriers to services for potential participants exist. The leading obstacle for parenting women is the lack of child-care for their children while in treatment. It was strongly emphasized that a woman's recovery was dependent on three key factors: herself, her social networks, and her community.

Partially based on the findings of this evaluation, this plan includes indicators which address policies and procedures for dealing with substance abusing women (Indicator 10) and for identifying, treating and/or referring victims of family violence, abuse or neglect (Indicator 14).

Prior Trauma Care of Intoxicated Patients as a Predictor of Subsequently Fatal Injury: The IHS has funded a study that includes the preliminary data collection, crude data reporting, and initial death certificate-hospital record linkage for alcohol related fatalities. The purpose of this study is to identify intervention opportunities associated with nonfatal, alcohol-related injuries reported in IHS emergency departments and clinics that could, over time, decrease alcohol-related injury death in the Billings, Montana, Service Units. This study is providing baseline data for post-intervention comparisons by expanding the existing database about alcohol-related injuries and death. The findings are being used to identify different intervention and prevention strategies directed at decreasing alcohol-related injuries and deaths in the Billings, Montana, Service Units. Injury-control efforts include a new policy regarding referrals by emergency room treatment staff to alcohol treatment staff. Prevention of alcohol-related injuries and deaths will also include activities focused on informing youth about the relationship between alcohol consumption and high-risk behavior. The findings of this evaluation effort underpin the interventions that are being used in achieving Indicator 26 in this plan addressing the reduction of unintentional injury hospitalization rates.

Resource Requirements Methodology Update: In the early 1970's, the IHS formulated the Resource Requirements Methodology (RRM) as a management tool to provide a comprehensive, systematic, and uniform process for estimating the level of resource requirements necessary to provide basic health care to IHS customers and to assist in the allocation of non-earmarked resources. To reaffirm the purpose of the RRM, a study was conducted in 1995 to determine the validity and accuracy of the present methodology for use in today's health care environment. Preliminary findings support the need to update the current methodology to meet the future program demands of the IHS. The will consist of the following phases: (1) Update Staffing

Criteria and Modules, (2) Formulate Needs Assessment Cost Model, and (3) Needs Assessment Model Training. This methodology is critical to planning the achievement of most of the health service related indicators identified in this plan.

Development of a Health Services Research Agenda for American Indian and Alaska Native Populations: The IHS and the Agency for Health Care Policy and Research cosponsored a health services research conference as a first step in a long-term agenda-setting process to identify the most important health services research issues facing AI/AN communities and their health care systems over the next 5 to 10 years. The health services research agenda is intended to promote collaboration among American Indian or Alaska Native organizations, tribal and urban health systems, medical communities, foundations, and government agencies to increase communications and produce research information on health program services for the American Indian or Alaska Native patient. The health services research agenda is also intended to provide a forum for discussing health care reform changes that are creating new directions in the Indian health care system.

New Directions for Evaluation

The IHS is responding to dramatic changes taking place inside and outside the Government including greater involvement of tribal governments in the Indian health care system, technological innovations, the changing patterns of disease to more chronic conditions, and the transfer of many Federal programs and resources to individual States. These changes will affect the IHS evaluation strategy in the coming years. Nevertheless, the IHS remains committed to comprehensively community-based, preventive, and culturally sensitive projects that empower tribes and communities to overcome health issues. Specific research and evaluation proposals currently in process include the following topics: evaluation of the effects of medical nutrition therapy on patient outcomes among Native Americans with newly diagnosed type II diabetics, evaluation of the elders clinic at the Zuni (New Mexico) Ramah Service Unit, and the evaluation of the impact of the Northern Cheyenne End-Stage Renal Disease Prevention Project.

In addition, the Director of the IHS has increased emphasis on several areas consistent with the DHHS Strategic Plan and the priorities identified by IHS stakeholders. These activities focus on women's health, youth, traditional medicine, elder care, and establishment of working relationships with Federal and State governmental agencies and will undoubtedly affect new directions for evaluation.